STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335371	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Endicott L L C	301 Nantucket Drive Endicott, NY 13760

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** 48895 Based on observations, record review, and interviews during the recertification and abbreviated (NY00352718) surveys conducted 10/28/2024-10/31/2024, the facility did not ensure residents had the right to a dignified existence for 1 of 2 residents (Residents #411) reviewed. Specifically, Resident #411 was served their meal in their room [ROOM NUMBER] minutes after their roommate was served and had completed their meal. Findings include: The facility policy, Resident Rights, dated 2/2022, documented employees should treat all residents with dignity. Resident #411 had diagnoses including diabetes, adult failure to thrive, and gastro-esophageal reflux disease. The 10/21/2024 Minimum Data Set assessment documented the resident was cognitively intact and ate independently. The 10/22/2024 comprehensive care plan for nutrition documented interventions including a regular consistency diet. During an interview on 10/28/2024 at 11:50 AM, Licensed Practical Nurse #19 stated meals came to the unit on 2 carts, at 12:00 PM and 1:00 PM. The residents did not use the dining room. The carts were divided to help with tray passing. They were supposed to be divided by hallway, but they were a few trays on the second cart for residents in the first hallway, and vice versa. During an interview on 10/28/24 at 12:46 PM, Resident #411 stated breakfast was delivered to them daily after 9:00 AM, and their lunch came on the second cart at 1:00 PM. Their roommate's tray came on the first cart, and they waited at least 30 minutes after their roommate was served before their tray would come. By the time Resident #411's meal tray came they were so hungry they would eat too fast, and it would make them feel uncomfortable. During an observation on 10/28/2024, Resident #411 was sitting in the hallway outside their room. - at 12:44 PM, the first meal tray cart arrived on the unit. - at 12:52 PM, the meal tray for Resident #411's roommate was served in the room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 1:25 PM, Resident #411 told an unidentified activities staff their meal tray should have been there 2 hours before. - at 1:30 PM, the second meal tray cart arrived on the unit, and Resident #411 was served their meal tray in their room (38 minutes after the roommate). The resident's roommate had completed their meal. During an observation on 10/29/2024 at 9:05 AM, Resident #411 was in their room. Their roommate had their meal tray and Resident #411 did not. During an observation and interview on 10/29/2024 at 1:06 PM, Resident #411's roommate stated they were served their lunch and refused it, so the staff took it away. Resident #411 stated they had not yet received their meal. Both residents were in the room together. Resident #411 stated they had always stayed in that room and previously got their meal on the first cart, when the roommate moved in their tray started coming on the second cart while the roommate continued to get their food on the first meal cart. Resident #411 stated it upset them to watch their roommate eat or turn away food when she was hungry. They were frustrated their mealtime had changed. During an interview on 10/29/2024 at 1:57 PM, Certified Nurse Aide #21 stated 2 meal carts were delivered to the unit, about 30 minutes apart. Residents should always be served together, especially if they roomed together. The trays in the cart were not always arranged by room. They stated they would try to pair roommate trays together if they could. Dietary was had been putting Resident #411's meal tray on the first cart, but they did not know what happened. They could only pass out trays they had, and it was not dignified for Resident #411 to watch their roommate eat while they waited for their tray. During an interview on 10/29/2024 at 2:05 PM, Resident Assistant #15 stated 2 meal carts were delivered to the unit at 2 different times. Resident #411's roommate's meal came on the first cart. They did not know why the carts were arranged that way. The residents should eat together in the same room. It was not dignified or fair to Resident #411 to have to watch their roommate eat and just sit there. They tried to deliver trays to the same room one after the other, as they should always eat together. During an interview on 10/30/2024 at 11:38 AM, Licensed Practical Nurse #14 stated meal trays should be packed based on the location of the room. Roommates should be served together. It was not dignified for a resident to watch another resident eat, especially when they were hungry. During an interview on 10/30/2024 at 11:11 AM, Registered Nurse Unit Manager #20 stated the dining room on the unit had been empty since they started at the facility about a month and a half ago and none of the residents ate in the dining room. The trays were passed in the order they came on the cart from the kitchen. Trays should come at the same time to residents that shared a room. It was not dignified for one resident to eat while the other waited for their food. The carts should have all the residents from one hallway and the second cart should be all the residents on the other hallway. 10 NYCRR 415.5(b)(1-3)

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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. 48895 Based on record review and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 2 of 3 residents (Residents #27 and #141) reviewed. Specifically, Residents #27 and #141 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident with timely Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) when Medicare Part A coverage was ending and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A as required. Findings include: The Center for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055, expiration date 1/31/26, documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending. The undated facility policy, [Advanced Beneficiary Notice] and [Notice of Medicare Non-Coverage] policy, documented when a resident was no longer eligible for skilled coverage under Medicare Part A, the facility must issue an [Advanced Beneficiary Notice] and [Notice of Medicare Non-Coverage] to the resident or their legal representative with a minimum notice of two days. The resident or legal representative must be notified in person or via phone. Document the representative's name, phone number, date, and time they were spoken to and send certified mail on the same day. 1) Resident #27 had diagnoses including muscle weakness, diabetes mellitus type 2, and osteoporosis. The 9/13/2024 Minimum Data Set assessment documented it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment and the resident had a Medicare-covered stay with a start date of 8/6/2024 and an end date of 9/13/2024. The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #27's effective end date of services was 9/13/2024. Business Office Manager #11's handwritten additional information documented the notice was issued over the phone by speaking with Resident #27's representative on 9/10/2024 at 2:15 PM, and the notice was sent by certified mail on 9/10/2024. Business Office Manager #11's handwritten note on the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 letter documented Resident #27's representative was spoken to on 9/10/2024 at 2:15 PM, no options were selected regarding the discussion with the representative. There was no documented evidence a United States Postal Service Certified Mail Receipt was sent to the resident's representative. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #141 had diagnoses including Parkinson's disease, severe protein-calorie malnutrition, and encephalopathy (disease of the brain). The 10/2/2024 Minimum Data Set assessment documented it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment and the resident had a Medicare-covered stay with a start date of 9/4/2024 and an end date of 10/2/2024. The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #141's effective end date of services was 10/2/2024. Business Office Manager #11's handwritten additional information documented the notice was issued over the phone by leaving a message for Resident #141's spouse on 9/30/2024 at 1:05 PM, and the notice was sent by certified mail on 9/30/2024. Business Office Manager #11's handwritten note on the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 letter documented Resident #141's spouse was contacted on 9/30/2024 at 1:05 PM. There was no documented evidence a United States Postal Service Certified Mail Receipt was sent to the resident's representative. During an interview on 10/29/2024 at 3:40 PM, Business Office Manager #11 stated they did not have the certified letter slips for Residents #27 and #141. The Advanced Beneficiary Notice was not completed for either resident. The Business Office Manager #11 stated they left a message for the representatives to call them back if they had any questions. They did not call back, and Business Office Manager #11 did not follow up with either representative. During a follow up interview on 10/31/2024 at 10:56 AM, Business Office Manager #11 stated the process for issuing the notification was to explain to the resident or resident representative they had the right to appeal, and they would receive a certified letter per the Medicare guidelines. They mailed the Notice of Medicare Non-Coverage and the Advanced Beneficiary Notice of Non-Coverage together via certified mail. Resident #27's representative was left a message on their machine; they never spoke with them regarding options for the resident. Resident #141's representative was spoken to on the phone, no options were selected, and they should have been. It was important to notify the resident and representative of the change in payor source. It was important to ensure the resident or representative had all their options and knew how to move forward. During an interview on 10/31/2024 at 12:01 PM, Resident #27's representative stated they never received a certified letter from the facility. The facility did not explain the ability to appeal the Medicare non-coverage of services. They were told to bring in as many financial records as they could, and the resident was automatically transitioned to private pay. During an interview on 10/31/2024 at 12:50 PM, Resident #141's spouse stated they never received a certified letter from the facility. The facility requested they bring in financial records for the resident. They were not given any options and did not know they could appeal the determination. They stated they would have appealed the decision if they knew they could. 10 NYCRR 483.10 (g) (18)

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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 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** 33421 37516 48895 Based on record review, observations, and interviews during the recertification and abbreviated (NY00351721 and NY00320653) surveys conducted 10/28/2024-10/31/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 4 of 4 resident units (Units 1, 2A, 2B, and 3) reviewed. Specifically, Units 2A, 2B, and 3 had unclean hallways, bathrooms, and resident room floors; the main kitchen and unit pantry areas had unclean areas; the resident scale on Unit 2A had dried debris; Resident #102's wheelchair had ripped armrests held together with tape; the main dining room toilets were out of order and contained brown liquid; and the facility air temperature was not maintained at a comfortable level on 10/26/2024 and 10/27/2024. Findings include: The facility policy, Cleaning Procedure Residents Rooms, revised 1/2024, documented housekeeping was responsible for cleaning: - Resident rooms and adjoining toilet areas (to be cleaned daily). - Public toilet areas and large bath/toilet areas located on the skilled nursing facility. - Nurses' stations, medicine rooms, and utility rooms. - Resident dining rooms. - Lounges, halls, and corridors. The facility policy, Quality of Life - Homelike Environment, revised 3/2024, documented residents were provided with a safe, clean, comfortable, and homelike environment and were encouraged to use their personal belongings to the extent possible. Characteristics that reflected a personalized, homelike setting included: - A clean, sanitary, and orderly environment. - Clean bed and bath linens that were in good condition. - Pleasant, neutral scents. - Comfortable and safe temperatures (71 degrees Fahrenheit to 81 degrees Fahrenheit). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, General Kitchen Cleaning, revised 4/5/2024, documented staff would maintain the sanitation of the kitchen through compliance with the cleaning schedule and would be recorded when completed. Resident Equipment: During observations on 10/28/2024 at 12:21 PM, 10/29/2024 at 9:12 AM, and 10/30/2024 at 9:32 AM, Resident #102's Broda (a specialized reclining wheelchair) chair had a ripped vinyl armrest on the right side that had surgical tape across the top. During an interview on 10/31/2024 at 10:43 AM, Licensed Practical Nurse #30 stated therapy issued resident wheelchairs. If there was an issue, they put in a ticket to maintenance and if they could not fix it, they would submit a ticket to therapy or talk to therapy directly. They stated Resident #102's Broda chair wheels did not work properly, and they submitted a ticket, and the Director of Therapy was aware. The right armrest was ripped and coming off. They reported the armrest but did not put in a ticket. During an interview on 10/31/2024 at 11:08 AM, Licensed Practical Nurse Unit Manager #6 stated maintenance and therapy maintained the Broda chairs. The arm rest was ripped because Resident #102 ripped it and they did not know who put the tape on it and did not notice the tape before 10/31/2024. They noticed the rip on 10/28/2024, but did not put in a ticket for repair, as they thought the resident was getting a new chair. The chair should be fixed to prevent any injuries. It did not look good and could be a dignity issue. During an interview on 10/31/2024 at 11:34 AM, Director of Therapy #31 stated Broda chairs were issued by therapy. If there were issues with the chair staff should submit a ticket to get it fixed. Maintenance attempted to repair chairs first, and if a replacement was needed, they would assume responsibility. They had not received any maintenance requests for Resident #102's chair, and they were not aware of the right armrest damage. The armrest needed to be replaced for dignity and safety concerns. During an interview on 10/31/2024 at 11:55 AM, the Director of Nursing stated damaged wheelchairs required staff to place a ticket to maintenance and if they could not fix the chair, they would notify therapy. There was a risk for skin tear, infection, pressure injury, and dignity issues. Staff had been educated on this issue before, and the facility added a new feature to the kiosk for staff to submit work orders. Unclean Environment: The following observations of Unit 2A were made on 10/28/2024: - at 11:22 AM, the floor in resident room [ROOM NUMBER] was unclean with dried debris and large, black scrape marks. - at 11:28 AM, both hallway floors were unclean with dried spills, stains, lint, dust balls and pieces of paper. The paint on the hall walls was peeling and there were black scrape marks on the floors and on the doors to resident rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 11:45 AM, the floor in resident room [ROOM NUMBER] was unclean with dried spills and crumbs. Bottle caps, empty sugar packets, small pieces of paper, dust balls, and used disposable cups were under and around the resident's bed. - at 12:24 PM, the large table at the end of the hall (near room [ROOM NUMBER]) had a dust film, and a large scrape with exposed splinters and strands of human hair; three vinyl upholstered chairs had crumbs on their seats, unclean armrests, and scraped and dented wooden frames; the resident scale near the table had tan-colored dried debris on the foot of the scale; and the floor under the table and near the resident scale had multiple large dust balls. During an observation on 10/29/2024 at 8:03 AM, room [ROOM NUMBER] had 6 snack wraps at the right side of the bed and stains on the floor. The floor was littered with small black debris. There was scattered debris in the fold of the fall mat. The following observations were made on Unit 2B: - on 10/28/2024 at 10:54 AM, Resident #410's family stated that cleaning was an issue for the facility. The resident's bathroom floor had debris, and there was staining around the toilet and the edges of the floor. - on 10/28/2024 at 11:08 AM, Resident #410's toilet continued to run for 11 minutes after the resident exited the bathroom. - on 10/28/2024 at 11:23 AM, the ceiling vent between rooms [ROOM NUMBERS], had a black substance on the vent louvers. - on 10/28/2024at 11:26 AM, there was a dark colored substance on the floor under the hand sanitizer between rooms [ROOM NUMBERS]. - on 10/28/2024 at 12:27 PM, the flooring between the nurse's station and the northwest stairwell was uneven with cracked and chipped tiles. There was a black leather chair that was ripped in multiple areas across the arms and back with a sign that documented, do not use. The treatment cart across from room [ROOM NUMBER] had a large amount of dust and debris collected around the wheels. - on 10/28/2024 at 1:42 PM, the floor near the nurse's station had brown colored stains and 40-50 dark dried spots. The walls had scrapes and scuffs throughout the hallways. The front of the nurse's station had several large clumps of dust and debris stuck to it. The doorway between units 2A and 2B had multiple scrapes and missing paint. On 10/29/2024 at 1:05 PM and 10/30/2024 at 10:07 AM, the window across from room [ROOM NUMBER], had a towel taped to it and had a bent screen. The window appeared open, but the towel was wedged in the gap. The following observations were made on the 3rd floor: - on 10/28/2024 at 10:31 AM, the shared bathroom for rooms [ROOM NUMBERS] had feces on the front of the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 10/28/2024 at 12:04 PM, room [ROOM NUMBER] had an approximate 12 inch by 2 inch dried spill on the floor between the two beds. - on 10/28/2024 at 12:08 PM, the shared bathroom for rooms [ROOM NUMBERS] had a commode with feces on it. - on 10/28/2024 at 12:56 PM, the 3rd floor dining room had unclean and sticky floors. - on 10/28/2024 at 1:32 PM, room [ROOM NUMBER] had many black spots covering most of the floor. - on 10/29/2024 at 8:34 AM, room [ROOM NUMBER] had many black spots covering most of the floor, the heater had rust, and the sink in the bathroom did not have water. The resident occupying the room stated their room was dirty and they did not like it. - on 10/30/2024 at 9:25 AM, the 3rd floor dining room had unclean and sticky floors. - on 10/30/2024 at 1:18 PM, a brown recliner near the 3rd floor nurse's station had rips across the back headrest. An unknown resident sat down in the chair after lunch. The following additional observations were throughout the facility: - on 10/28/2024 at 10:41 AM, the kitchen dish room grease trap had gray color debris on the trap encasement and the floor surrounding the trap. The main kitchen floor had black marks, food particles, and paper products throughout the area. The dry storage area had leaves on the floor. The exit door was blocked by a cart with folded cardboard boxes on top and a large garbage pail. The Assistant Food Service Director stated the kitchen staff were short due to illness. - on 10/28/2024 at 2:45 PM, the men's room in the dining room had a sign that documented, out of order, the door was unlocked, and the toilet was full of foul-smelling brown liquid. The women's room toilet was full of foul-smelling brown liquid. The water fountain between the bathrooms had stagnant brown liquid pooled in the basin. - on 10/28/2024 at 3:22 PM, the elevator floor was uneven and had several chipped flooring pieces. - on 10/28/2024 at 3:25 PM, the conference room had multiple dried black debris stuck to the floor. - on 10/30/2024 at 11:32 AM, the men's room in the second-floor dining room had a sign that documented, out of order, the door was unlocked, the toilet had a brown foul-smelling substance. The water fountain between the 2 bathrooms had a brown liquid at the drain, and dried brown substance that created rings above the water line. The women's room had a sign that documented, out of order, the door was unlocked, the toilet had a brown foul-smelling substance and rings of dried brown substance. The odor from the bathroom was very strong upon opening the door. At 12:51 PM, residents were eating in the dining room with the unclean bathrooms. During an interview on 10/28/2024 at 1:09 PM, Certified Nurse Aide #16 stated they had not seen a housekeeper on the unit (2A) all day. The housekeeper called out a lot. The other unit housekeepers were always there. The floors, walls, and resident rooms on the unit were routinely dirty. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2024 at 9:26 AM, Certified Nurse Aide #32 stated housekeeping was responsible for cleaning the unit. They were there Monday through Friday until 3:00 PM. The rooms did not look clean. Floors were dirty in resident rooms. The black marks on the floor were dirt. They used a washcloth on the dark spots, and they cleaned up easily. The water in room [ROOM NUMBER] did not work. There was a weekend the facility did not have a housekeeper because they were short staffed. During an interview on 10/30/2024 at 9:16 AM, Licensed Practical Nurse Unit Manager #17 stated Unit 2A was not as clean as it could be. The housekeeper was out a lot. They and unit staff usually had to follow behind the housekeeper, especially if there was a new admission going into a room. They cleaned the dust balls and debris from under the beds. They had spoken to the housekeeping supervisor about the lack of cleaning on the unit, but nothing seemed to change. During an interview on 10/30/2024 at 9:25 AM, Licensed Practical Nurse #9 stated housekeeping was on the units Monday through Friday, and there were only 1 or 2 staff for the whole facility. Floors were dirty and sticky at times. Housekeeper #33 was assigned to the third floor, and they were really good if they were told about something. If there was feces on the toilet, it was everyone's responsibility to clean it. If it was not cleaned and another resident used the toilet, it could be an infection control concern. The dirty and sticky floors were not homelike. During an interview on 10/30/2024 at 11:17 AM Housekeeper #18 stated their usual unit to work on was 2A, but since 2B was the rehabilitation unit with more admissions, they would get pulled over to that unit frequently to assist with cleaning. Their usual cleaning routine when they arrived on the unit was the pantry first, then shower rooms, the nurses' station, clean and dirty utility rooms, and then bathrooms. At 9:30 AM they would start cleaning resident rooms. Their supervisor had told them to use the cleaning spray first on the floors, but they dusted the floors then sprayed. They would then go back into the resident room and clean the cabinets and dressers. They were responsible for cleaning rooms for new admissions and room changes. Deep cleaning a room involved moving all equipment and furniture, and cleaning bed frames and mattresses. Normally the facility had extra housekeepers, but they did not always show up for work. Any extra housekeepers were sent to Unit 2B. They let maintenance know about walls that needed painting, scrapes on the walls, and broken equipment. They cleaned resident scales. Nursing was responsible for wheelchair cleanings. They let nursing know if they had any issues with a resident when they attempted to clean a room. If a resident told them to get out they would leave and then reapproach later. Sometimes residents would only let them empty the trash. If they did not get to all the resident rooms on the unit during their shift, their supervisor told them to start all over again on the unit the next day. There were no housekeepers on the evening shift. The facility had some night custodians that were being trained to clean rooms because they were short housekeeping staff. Unit 2A was dirty on 10/28/2024 because that was their day off and there was not another housekeeper who replaced them. During an interview on 10/31/2024 at 7:37 AM, Housekeeper #33 stated they had the same routine every day. They were responsible for the entire third floor. Their routine was to clean every room and make sure the sink and toilets were cleaned, sweep, mop, dust, deodorize the room and take out the garbage. When they were not there the nursing staff would clean up after the residents. They did not recall seeing feces on the toilet in room [ROOM NUMBER]. The housekeeping department was short staffed. They tried to get in and out of every room timely. They did not know if the sink in room [ROOM NUMBER] worked. The black substance on the floor in room [ROOM NUMBER] was sticky from urine with dirt and grime. They stated the floors needed to be waxed, but the facility no longer had someone to do that. If the room was not clean, it was not homelike for the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Endicott L L C	301 Nantucket Drive Endicott, NY 13760

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/2024 at 9:39 AM, the Assistant Food Service Director stated the main kitchen floors were cleaned every Friday by a contractor. They were swept and mopped by kitchen staff after every meal. The dietary staff was short on 10/27/2024 and the floors were not cleaned by the time the surveyor observed them. The grease trap under the dishwasher had leakage issues and maintenance was aware. The trap was supposed to be cleaned daily and the debris on it was due to not being cleaned daily. There should not be leaves on the dry storage area floor. During an interview on 10/31/2024 at 10:35 AM the Administrator stated the Laundry Supervisor was currently overseeing housekeeping because the Housekeeping Supervisor was on leave. They had turnover with housekeeping staff. Housekeepers worked day and evening shifts. The custodians on evenings were cleaning resident rooms, sweeping, mopping, and taking out the garbage if the day shift housekeepers could not get to those tasks. The Housekeeping Supervisor would do weekly environmental rounds. They would address unclean areas right away with the housekeepers. The expectation for resident rooms was they should be thoroughly cleaned, including underneath the beds. Rooms were deep cleaned for new admissions and discharges. Maintenance was in charge of painting walls. During an interview on 10/31/2024 at 11:26 AM, Housekeeper #35 stated they were assigned to Unit 2B and started cleaning each day in the pantry and common areas, then took trash from the resident rooms and common areas. This allowed the resident to get morning care. They had a goal to complete one hallway each day but could not always get through the whole hallway. They would do the other side of the unit the following day and rotate back and forth. Some days it was difficult to finish one side of the unit, depending on admissions and discharges. It took about 45 minutes to an hour to deep clean a room after discharge, the unit sometimes had multiple discharges in a day. Cold Environment/Heat Issue: During an interview on 10/28/2024 at 10:54 AM, Resident #410's family stated they visit 6 days a week. The temperature in the facility on Saturday (10/26/2024) and Sunday (10/27/2024) was very cold. They brought Resident #410 winter gloves to wear. During an interview on 10/28/24 at 12:46 PM, Resident #411 stated it was cold this past weekend, very uncomfortable. They asked the nursing staff about the heat and was given extra blankets. They stated nursing handed out extra blankets to everyone. The staff told Resident #411 they reported the outage, but there was nothing else they could do. During an observation on 10/28/2024 at 1:08 PM, an unknown staff member was overheard telling another staff member that it was very cold over the weekend, and they had to wear coats in the building. They stated the certified nurse aides went around and turned up all the thermostats on the unit, with no change. During an interview on 10/29/2024 at 8:35 AM, Resident #119 stated they were told the boiler was turned off on Thursday, but it was so cold over the weekend nursing staff were wearing their outside coats while providing care. They stated that management and maintenance were asking staff for the actual temperature, but the staff stated they had no thermometer on the thermostat, so they did not know what the actual temperature was. Resident #119 was told that maintenance did not work on the weekend so there was nothing that could be done. Resident #119 stated it was bitter colder and they had to wrap up in a blanket all day. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/24 at 12:30 PM, the Administrator stated the Maintenance Director was responsible for monitoring the air temperature in the facility and documenting it. He had been out of work since 10/18/2024, and there were no air temperature logs for the dates requested, 10/23/2024 to 10/29/2024. During an interview on 10/29/24 at 2:05 PM, Resident Assistant #15 stated they worked both days over the weekend. It was cold in the building, and they had to wear a long sleeve shirt and a sweatshirt. The residents complained that it was cold. They handed out extra blankets to the residents. It was very cold, under 70 degrees Fahrenheit. During an interview on 10/30/24 at 11:38 AM, Licensed Practical Nurse #14 stated they worked on Saturday and Sunday. The facility was cold. The residents complained that it was not comfortable, and they were cold. The facility should be comfortable and homelike for the residents. During an interview on 10/30/2024 at 2:16 PM, the Corporate Administrator stated there were made aware of the facility being cold at 9:55 AM on 10/27/2024 via text message from the Director of Nursing. The Assistant Maintenance Director came in and restarted the boiler with confirmation provided to the Corporate Administrator via text message at 11:33 AM on 10/27/2024. They did not know why the boilers were off. The Director of Maintenance did not document when the boilers were turned on or off. If there was an issue, they would call the on-call maintenance staff and they would look at the boiler to see if it was on or off. During an interview on 10/30/24 at 2:37 PM, the Director of Nursing stated they were notified by the supervisor that unit 2B was freezing at 9:36 AM on 10/27/2024. The Director of Nursing stated they reported to the Corporate Administrator at 9:49 AM on 10/27/2024 when they were told the facility was 62 degrees Fahrenheit. The Assistant Maintenance Director communicated that the boiler was working at 11:30 AM on 10/27/2024. During an interview on 10/30/2024 at 2:55 PM, the Assistant Maintenance Director stated they received a message from the Director of Maintenance that there was no heat on unit 2B. The boilers were not running, and they were not sure why. They stated that the 3 staff in the maintenance department did not turn them off, the Director of Maintenance could have, but if they did, they did not communicate that to the rest of the department. The Assistant Maintenance Director stated they stayed for about 45 minutes to ensure the boilers were running appropriately. They did not monitor the air temperature while they were here. 10 NYCRR 415.29(j)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48446 Based on observations, record review. and interviews during the recertification and abbreviated (NY00355520 and NY00332658) surveys, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 10 residents (Resident #9) reviewed. Specifically, Resident #9 was not shaved and dressed as care planned. Findings include: The facility policy, Activities of Daily Living, revised 6/2021, documented staff would assist and encourage all residents to their highest practicable level of independence and provide the necessary support in all activities of daily living functioning. Activities of daily living would be completed daily by the resident with the assistance of the facility resident care staff as needed. If a resident resisted or refused care the nurse would be notified and they would document in the progress notes of the resident's chart. Resident #9 had diagnoses including muscle weakness and need for assistance with personal care. The 9/21/2024 Minimum Data Set assessment documented the resident was cognitively intact, able to make their needs known, and required partial to moderate assistance of one for upper and lower body dressing and personal hygiene. The 10/30/2024 Comprehensive Care Plan documented under the topic of Activities of Daily Living/Mobility the resident required partial to moderate assistance of one for upper and lower body dressing and for personal hygiene, including shaving. The 10/2024 certified nurse aide tasks documented the resident's last shower was on 10/24/2024 and they had a bed bath on 10/29/2024. The resident was observed: - on 10/28/2024 at 1:17 PM, sitting in their chair wearing a hospital gown that had dried food on it. - on 10/30/2024 at 1:37 PM, sitting in their chair wearing a hospital gown. - on 10/30/2024 at 4:21 PM, lying in their bed wearing a hospital gown. They stated they would like to be dressed in street clothes, but they had no clothes. They stated even though they had a beard they would like to be shaved and have a mustache. Staff usually shaved them but did not last night and they were not sure why. During an interview on 10/31/2024 at 7:27 AM Certified Nurse Aide #24 stated Resident #9 was cognizant, their shower day was on Tuesdays, and they did not refuse care. Showers included shaving. The resident did not have a lot of clothes and they had gone to clothing donation and brought in clothes for the resident. The resident got a bed bath on 10/29/2024 but they were not shaved. They should have asked the Unit Manager to shave the resident but did not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 7:49 AM Licensed Practical Nurse #9 stated when the certified nurse aides gave showers, they also shaved residents. If a resident did not get shaved or showered it could make them feel neglected and embarrassed. During an interview on 10/31/2024 at 8:00 AM Licensed Practical Nurse Unit Manager #3 stated Resident #9 did a lot of their own care. They were always in a gown, and they did not know why. Residents should be shaved on their shower day or any day if requested. If a resident was wearing a hospital gown all the time and not shaved it could make them feel depressed, sad, and decrease their self-worth. During an interview on 10/31/24 at 11:08 AM the Director of Nursing stated they expected residents that wanted to be shaved or stay in a hospital gown to have it documented in their care plan. They expected residents who wanted to be dressed to be dressed. Any staff could get clothes for a resident. Resident #9's care plan did not document they preferred to be in a gown or not shaved. Wearing a hospital gown or not being shaved was a dignity issue and could make the resident embarrassed and not want to leave their room. 10NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48446 Based on observations, record review, and interviews during the recertification and abbreviated (NY00355520, NY00352718, NY00351721, and NY00320653) surveys conducted 10/28/2024-10/31/2024 the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 of 4 residents (Resident #3 and #8) reviewed. Specially, Resident #3 was administered the wrong dose of rapid-acting insulin and Resident # 8 did not have their oxygen tubing or humidifier bottle regularly changed. Findings include: The undated facility policy, Insulin Administration and Sliding Scale Management, documented blood glucose levels obtained via fingerstick were done at intervals specified by the primary care provider note. This was done to assess and monitor blood glucose levels of residents with hypoglycemia and those with diabetes mellitus to facilitate prompt and/or continued treatment of diabetic residents. Insulin was administered as ordered by the primary care provider and both finger stick results and the administration site were documented in the electronic medication administration record. The facility policy, Medication Administration, revised 6/2021, documented medications were administered by a registered nurse or licensed practical nurse in a way that ensured the residents safety and documented in the electronic medical record. Medications were administered at the right time, to the right resident, using the right dose, the right medication, and the right route. The facility was unable to provide a policy regarding oxygen use. 1) Resident #3 had diagnoses including chronic obstructive pulmonary disease (lung disease), anxiety, and diabetes. The 10/2/2024 Minimum Data Set assessment documented the resident had intact cognition, was dependent on staff for most activities of daily living and received insulin every day for the last seven days. The Comprehensive Care Plan initiated 2/9/2023 documented the resident had diabetes mellitus and underlying kidney complications. Interventions included monitoring blood sugars, administering insulin, and monitoring for signs of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). The 10/17/2024 medical order entered by Nurse Practitioner #22 documented finger sticks every day before meals and at bedtime and administration of Fiasp (insulin aspart, rapid-acting insulin) 100 units/milliliter in 3 milliliter pen injector subcutaneous with the sliding scale (amount of insulin administered was based on finger stick blood sugar results): - For a blood sugar of 201-250 milligrams/deciliter, give 8 units of insulin aspart. - For a blood sugar of 251-300 milligrams/deciliter, give 10 units of insulin aspart. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an initial screening and interview with Resident #3 on 10/28/2024 at 11:37 AM, Licensed Practical Nurse #23 entered the room to administer the resident's insulin. Licensed Practical Nurse #23 administered 10 units of Fiasp (insulin aspart) 100 units/ml in Resident #3's right arm for a blood sugar of 228 milligrams/deciliter. Licensed Practical Nurse #23 showed the surveyor the insulin pen set at 10 units. The 10/28/2024 Medication Administration Record documented Licensed Practical Nurse #23 administered 8 units of Fiasp (insulin aspart) 100 units/milliliter in the resident's right abdomen for the 11:30 AM finger stick result of 228 milligrams/deciliter. During an interview on 10/31/2024 at 8:38 AM, Licensed Practical Nurse #23 stated they were responsible for administration of medications when the units were short staffed, and they administered medications to Resident #3 on 10/28/2024. After they administered insulin, they documented the dose of insulin and the site of administration in the electronic record. They stated they administered 10 units of insulin in the right arm to Resident #3 on 10/28/2024 for a blood sugar of 228 milligrams/deciliter. If they documented 8 units of insulin in the abdomen on 10/28/2024, that was inaccurate and would be a documentation error, because that was not what they administered. If someone documented the wrong dose or site of insulin administration that would be a safety concern for the resident. During an interview on 10/31/2024 at 9:01 AM, Nurse Practitioner #22 stated when they ordered a sliding insulin scale for a resident with diabetes, they expected it to be followed. If a resident received a higher dose of insulin than was ordered the resident could become hypoglycemic (low blood sugar). They were not notified that Resident #3 received the wrong dose of insulin and should have been notified. During an interview on 10/31/2024 at 11:08 AM, the Director of Nursing stated if a resident had an order for 8 units of insulin, they expected 8 units of insulin to be administered. If a resident was prescribed 8 units of insulin and administered 10 units, it was a medication error, and the resident could have a low blood sugar. They expected all medications to be documented accurately. If insulin was administered in the arm the documentation should not say abdomen. 2) Resident #8 had diagnoses including chronic obstructive pulmonary disease (lung disease), chronic respiratory failure, and pneumonia. The 8/7/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required assistance of one for most activities of daily living, and received continuous oxygen therapy. Resident #8 did not have a Comprehensive Care Plan related to respiratory diagnoses, oxygenation. and supplemental oxygen use. A 3/25/2024 medical order by Nurse Practitioner #22 documented oxygen therapy of 1 liter per minute via nasal cannula, every day, on every shift, with oxygen saturation maintained greater than 92%, change oxygen tubing every and humidifier bottle weekly on Wednesday. The order was discontinued on 5/7/2024 with attempt to use room air. The 5/10/2024 medical order by Nurse Practitioner #22 documented oxygen therapy of 1 liter per minute via nasal cannula, every day, on every shift, with oxygen saturation maintained greater than 88%. The order did not include changing of oxygen tubing or humidifier bottle. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/28/2024 at 11:27 AM, Resident #8 was in bed utilizing supplemental oxygen at 1 liter per minute via nasal cannula. The humidification canister was dated 9/2/2024 and had minimal water at the bottom of the canister that did not completely cover the bottom. The resident's oxygen delivery tubing was not dated. The 10/28/2024 progress note by Nurse Practitioner #22 documented Resident #8 was assessed for increasing shortness of breath, not being able to catch their breath, and not feeling well. Crackles were heard in the left lower right lung and diminished lung sounds in the upper and lower right and left lung. The resident was diagnosed with acute pneumonia. The 10/2024 Medication and Treatment Administration Record documented oxygen therapy at 1 liter per minute via nasal cannula, there was no documented evidence the oxygen tubing or humidifier bottle were changed. During an observation on 10/30/2024 at 1:23 PM, Resident #8 was in bed utilizing supplemental oxygen at 1 liter per minute via nasal cannula, the oxygen delivery tubing was not dated. During an interview on 10/31/2024 at 7:49 AM, Licensed Practical Nurse #9 stated it was the nurse's responsibility to monitor oxygen. They made sure oxygen was on the right setting, the humidification canister had water in it, and the tubing and humidifier bottles were labeled. This was documented every shift on the medication administration record. It was the night shift nurse's responsibility to check and change the oxygen delivery tubing and humidification canister weekly and document on the medication administration record. They stated if the humidification canister was dated 9/2/2024 on 10/28/2024, it was not changed weekly as ordered. If there was no order, it would not be on the Medication Administration Record, and staff would have no way of knowing the tubing and canister required changing. If the tubing and canister were not changed weekly residents could get sick and get a respiratory infection. Licensed Practical Nurse #9 stated Resident #8 was on oxygen and was diagnosed with pneumonia on 10/28/2024. During an interview on 10/31/2024 at 8:00 AM, Licensed Practical Nurse #3 stated all nursing staff monitored oxygen. When a provider ordered oxygen, there was an oxygen template nurses used to ensure that along with the order for oxygen therapy there was an order for the humidification bottle and tubing to be changed and dated weekly. This was done weekly on the night shift for the safety of residents and to prevent infections. If the order was not placed properly, the humidification bottle and tubing would not be changed weekly, and residents could get an infection. Resident #8 should not have had a nearly empty humidification canister labeled 9/2/2024 on 10/28/2024. They were diagnosed with a respiratory infection on 10/28/2024. During an interview on 10/31/2024 at 8:38 AM, Licensed Practical Nurse #23 stated on 10/28/2024 they were notified by Licensed Practical Nurse #28 Resident #8 was having difficulty breathing. They were shown a hole in the humidification canister and changed the canister and dated it. If the humidification canister was not labeled properly or does not have water, residents could be short of breath and get sick. During an interview on 10/31/2024 at 9:01 AM, Nurse Practitioner #22 stated oxygen was maintained by nursing staff with the humidification canister and tubing changed weekly for infection control reasons. Resident #8 wore oxygen and was diagnosed with pneumonia on 10/28/2024. Having outdated and empty humidification canister could contribute to the development of pneumonia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/2024 at 11:08 AM, the Director of Nursing stated oxygen tubing and humidification canisters were changed weekly and labeled. If the oxygen order was not put in properly, it would not populate to the treatment administration record and would not get completed. If the oxygen tubing and canister was not changed weekly a resident could inhale bacteria in their lungs that could cause infection. A resident should not have an oxygen humidification canister dated 9/2/2024 when it was 10/28/2024. 10 NYCRR 415.12

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48446 48895 Based on observations, record review, and interviews during the recertification survey conducted 10/28/2024-10/31/2024, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meal test trays reviewed (10/29/2024 and 10/30/2024 lunch meals). Specifically, food was not served at palatable and appetizing temperatures during the lunch meals on 10/29/2024 and 10/30/2024. Additionally, Residents #18 and #85 stated the food was not flavorful and was cold. Findings include: The facility policy, Food Temperature and Test Tray Audits, revised 4/5/2024 documented test trays would be audited periodically to ensure that food temperatures, food quality, and the overall dining experience was at optimal levels. Minimum temperatures at the time of service were defined as: - Soups, hot entrees, starches, and hot vegetables served greater than 135 degrees Fahrenheit; - Cold beverages, cold desserts (such as pudding and gelatin), and cold entrees served less than 55 degrees Fahrenheit; - Milk and milk products served less than 45 degrees Fahrenheit; and - Hot beverages served greater than 140 degrees Fahrenheit. During an interview on 10/28/2024 at 11:08 AM, Resident #18 stated the food was not good and was not hot. During an interview on 10/28/2024 at 12:20 PM, Resident #85 stated they got their meal trays last, and the food was cold and lacked flavor. During a Third Floor meal observation on 10/29/2024 at 12:50 PM, Resident #18 was served their lunch meal tray. A replacement tray was ordered, and Resident #18's original meal tray was tested . The fried chicken was measured at 129.2 degrees Fahrenheit, the yogurt was 54.5 degrees Fahrenheit, and the cooked carrots were 134.4 degrees Fahrenheit. During an interview on 10/29/2024 at 1:12 PM, Certified Nurse Aide #36 stated Resident #18 usually got their tray last, and their tray was on top of the hot cart and not inside. They delivered the trays on top of the cart first, so they did not get cold. They often heard residents complain about the food being too cold, undercooked, and having no flavor. If the residents did not like the food, they offered them an alternative. The kitchen was short staffed and asked the nursing staff to go down to the kitchen to get the alternative food, but they could not leave the unit because they had other residents to care for. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335371	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Endicott L L C	301 Nantucket Drive Endicott, NY 13760

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 1:57 PM, Certified Nurse Aide #21 stated that residents complained the food did not look or smell good. During a Third Floor meal observation on 10/30/24 at 1:27 PM, the second meal cart arrived on the unit. At 1:31 PM, Resident #85 was served their lunch meal tray. A replacement tray was ordered, and Resident #85's original meal tray was tested . The broccoli was measured at 132.1 degrees Fahrenheit, the pineapple was 47.3 degrees Fahrenheit, the cold water was 59.2 degrees Fahrenheit, and the milk was 52.7 degrees Fahrenheit. During an interview on 10/31/2024 at 9:38 AM, the Assistant Food Service Director stated hot food should be served hot, 180 degrees Fahrenheit coming from the tray line and held above 165 degrees Fahrenheit when served to the residents. Cold food should be cold, 40 degrees Fahrenheit or below when served to the residents. Food should be enjoyable and palatable, so the residents would eat it. The enjoyment of eating starts with the eyes and the appearance of the food. The Assistant Food Service Director stated the broccoli at 132 degrees Fahrenheit was an appropriate temperature; the pineapple at 47.3 degrees Fahrenheit, cold water at 59.2 degrees Fahrenheit, and milk at 52.7 degrees Fahrenheit were all high. The best range for hot food was 130-145 degrees Fahrenheit. They stated the ovens did not always work and heat evenly and had been that way for a couple of years. The maintenance team had worked on the ovens numerous times, but they were old. The Director of Maintenance and Administrator were both aware of the problems with the ovens. 10NYCRR 415.14(d)(1)(2)

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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. 33421 Based on observations, record review, and interviews during the recertification and abbreviated (NY00320653 and NY00351721) surveys conducted 10/28/2024-10/31/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 staff member (Social Worker #5) and 1 resident (Resident #160) observed. Specifically, Social Worker #5 entered a COVID-19 positive room wearing an N95 mask inappropriately and Resident #160 did not have appropriate transmission-based precautions signage in place. Findings included: The facility policy, Infection Prevention and Control Program, revised 2/2021, documented the program was intended to prevent the transmission of communicable diseases and infections. Prevention of infection included implementing appropriate isolation precautions when necessary and following guidelines such as those of the Centers for Disease Control. Those with potential direct exposure to blood or bodily fluids were required to use appropriate precautions and personal protective equipment. The facility policy, Isolation- Categories of Transmission-Based Precautions, revised 2/2021, documented the 3 types of transmission-based precautions were contact, droplet, and airborne. Any resident on contact precautions required staff to wear a disposable gown and gloves upon entering the room and before leaving the room. The policy did not specifically document enhanced barrier precautions. The facility policy, COVID-19 Action Plan, revised 6/7/2024, documented health care providers entering a COVID-19 positive resident room should wear a N95 mask. 1) Resident #148 had diagnoses including COVID-19 and dementia. The 7/30/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was independent with ambulation and bed movement, and required moderate to maximum assistance with dressing and hygiene. The 10/21/2024 Licensed Practical Nurse Manager #6 progress note documented unit wide COVID-19 testing was done, and Resident #148 had positive results. Isolation precautions were in place. The 10/21/2024 physician order documented isolation precautions, contact precautions, COVID-19 precautions, and droplet precautions. The 10/21/2024 Comprehensive Care Plan documented the resident had COVID-19. Interventions included obtain cart with personal protective equipment, contact and droplet isolation precautions, and post a sign on the doorway. A 10/28/2024 Licensed Practical Nurse Unit Manager #6 progress note documented Resident #148 was on contact/droplet isolation precautions. (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 observation and interview on 10/28/2024 at 11:00 AM, Licensed Practical Nurse Unit Manager #6 stated Resident #148 tested positive for COVID-19 and was on droplet precautions. During the interview, Social Worker #5 was observed wearing a surgical mask covering their nose and mouth and a N95 mask over the surgical mask. Social Worker #5 donned a gown and gloves and entered Resident #148's room with N95 mask over the surgical mask. The resident's doorway had a sign that the resident was on droplet precautions. The 10/21/2024 Social Worker #5 general orientation schedule and sign off documented they received N95 Fit testing (ensuring proper mask and fitting) and donning/doffing of personal protective equipment with N95 competency on day 2 of orientation. The undated Donning and Doffing Personal Protective Equipment with N95 Competency, signed by Social Worker #5, documented they correctly fit the N95 snugly to their face. During an interview on 10/30/2024 at 4:26 PM, Certified Nurse Aide #7 stated all staff were supposed to wear a N95 mask on the unit as there were COVID-19 positive residents who wandered on the unit. The N95 mask was worn to prevent staff and other residents from getting sick. The N95 was to be worn against the face with a surgical mask over it to ensure a good seal against the face thereby not allowing germs to seep through the mask. During an interview on 10/30/2024 at 4:34 PM, Licensed Practical Nurse Manager #6 stated facility policy was for staff to wear a N95 at all times on the unit. The purpose of the N95 mask was to create a tight seal against the face so germs could not get through to the mouth and nose. All unit staff were educated on the proper wearing of N95 masks around 10/21/2024. A surgical mask may be worn over the N95. If the surgical mask was worn between the face and the N95 mask, a tight seal could not be maintained. During an interview on 10/30/2024 at 4:49 PM, Infection Control Nurse #8 stated staff were supposed to wear a N95 mask at all times on the dementia unit as there were COVID-19 positive residents that wandered the halls without a mask on. Staff were educated during orientation, yearly, and as needed. The N95 mask was to be worn tightly against the face to prevent germs from seeping through to the wearer's nose and mouth and prevent inhaling the germs. Wearing a surgical mask between the N95 and the face would not allow a tight seal. All staff were recently educated on proper N95 wearing. Informal audits were being done, there had been staff that were not wearing masks correctly, and reeducation was done on the spot. There was signage on the entry doors to the unit about N95 mask wearing. During an interview on 10/30/2024 at 5:00 PM, the Director of Nursing stated staff were expected to follow the COVID-19 outbreak action plan, which included wearing a N95 mask correctly. The N95 was to be worn against the face to maintain a tight seal to prevent germs from entering the nose and mouth. A surgical mask could be worn over the N95. All staff were recently educated on proper N95 mask wearing. During an interview on 10/31/2024 at 10:06 AM, Social Worker #5 stated they started working at the facility about 3 weeks ago and was educated on proper N95 mask wear during orientation. The N95 was to be put on prior to entering the unit. The N95 was to be worn against the face for a tight seal to prevent pathogens from being inhaled via the nose or mouth. The social worker stated they made a mistake of having the surgical mask between the face and N95 mask prior to entering Resident #148'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	2) Resident #160 had diagnoses including skin abscess of the buttocks and pressure ulcer of the back, buttock, and hip. The 10/25/2024 Minimum Data Set assessment documented the resident was cognitively intact, was totally dependent for most activities of daily living, was frequently incontinent of bowel and bladder, had a Stage 3 (full thickness tissue loss) pressure ulcer, a surgical wound, an intravenous line for fluids, and received an antibiotic. The 10/23/2024 physician order documented enhanced barrier isolation precautions due to intravenous line and open wounds. The 10/30/2024 Comprehensive Care Plan documented the resident had a Stage 3 pressure ulcer on the left gluteal (buttocks) region, a surgical wound on the right gluteal region, required total dependency with most activities of daily, was incontinent of bowel and bladder, and had open wounds. Interventions included enhanced barrier precautions and post sign on door, check and change every 2 hours, 2 staff assistance with rolling/shower/bathe, monitor wound and dressing, turn and position every 2 hours, and incontinence care after each episode. The 10/30/2024 Licensed Practical Nurse Manager #17 progress note documented Resident #160 had a room change. During an observation on 10/31/2024 at 10:30 AM, there was no sign posted near the entrance to Resident #160's room indicating enhance barrier precautions were in effect. Resident #160 was lying in bed. There were two unidentified certified nurse aides changing the resident's incontinence briefs and performing incontinence care. The certified nurse aides were not wearing gowns or gloves. During an interview on 10/31/2024 at 10:41 AM, Licensed Practical Nurse #19 stated Resident #160 was on enhanced barrier precautions for open wounds. There should be a sign on the doorway, identifying the resident was on contact precautions and staff were to wear a gown and gloves when in the room and performing care. The purpose was to prevent contamination from the wound and potentially spreading an infection to another resident. The resident was moved from another room on 10/30/2024 and their current room did not have signage posted. During an interview on 10/31/2024 at 10:51 AM, Registered Nurse Manager #20 stated the resident had open wounds and was on isolation precautions. There should be signage on the doorway indicating what type of precautions the resident was on and the personal protective equipment required by staff. The risk of not wearing the equipment was spreading infection to the staff member or to another resident. During an interview on 10/31/2024 at 11:08 AM, the Director of Nursing stated if a resident was on enhanced barrier precautions, signage was to be placed on the doorway to communicate to staff what personal protective equipment was required to be worn. If a resident was moved to a different room, the signage should be placed on the doorway to the new room. They stated the resident's room had no signage on the doorway and there should be. 10 NYCRR 415.19(a)(b) 48446