STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335377	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews conducted during the recertification survey and abbreviated survey (Case #NY00373240), the facility did not ensure each resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life for five (5) (Resident #'s 4, 8, 22, 61, and 265) of 32 residents reviewed. Specifically, (a) Resident #'s 4, 8, and 22 who resided on the same nursing unit, expressed feeling degraded when they would ask for help; (b) Resident #61 expressed feeling like they were an object and not a human being when they accidentally defecated in their incontinence brief and the Certified Nurse Aides that helped them discussed it in an undignified manner (c) Resident #265 was crying when they expressed feeling humiliated when they had a bowel movement in their bed because the Certified Nurse Aide would not bring them a bedpan upon request. This is evidenced by: The undated Policy and Procedure titled, Resident Rights, Dignity and Respect, documented it was the policy of the facility to ensure that residents were maintained at the highest practicable level of well-being, including the protection of right to dignity. The Policy and Procedure titled, Resident Abuse Prevention and Reporting, revised 4/2024, documented it was the policy of the facility that all residents were treated with respect and dignity. It documented the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Resident #22: Resident #22 was admitted to the facility with diagnoses of cerebral infarction (stroke) without residual deficits, chronic obstructive pulmonary disease (disease that restricts breathing), and type 2 diabetes (happens when the body cannot use insulin correctly and sugar builds up in the blood). The Minimum Data Set (an assessment tool) dated 3/26/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The undated Certified Nurse Aide instructions for resident's care report, documented Resident #22 needed extensive assistance with toilet use. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/01/2025 at 9:32 AM, Resident #22 stated when they put their call light on, some Certified Nurse Aides would come into the room and tell them in that they were not their aide, then turn the call light off, leave the room and not come back. They stated it could take one (1) to three (3) hours for someone to finally come in and help them. Resident #22 stated they needed help with using the bathroom and said they had laid in their bed soaking wet after having an accident because Certified Nurse Aides did not respond to the call. Resident #22 stated they felt degraded when Certified Nurse Aides refused to help them. Resident #22 further stated Certified Nurse Aides would argue and fight about their assignments in front of them and other residents, and Certified Nurse Aides and would look directly at them and say that they were not assigned to care for them. During an interview on 5/08/2025 at 2:51 PM, Registered Nurse #1 stated they felt very strongly about maintaining dignity for all residents. They further stated that if a call light was on, a Certified Nurse Aide was supposed to address whatever the resident needed. If they needed a nurse, the Certified Nurse Aide was to leave the light on and then go and get the nurse. They stated if the light was turned off, the resident would not be attended to. Registered Nurse #1 stated they were aware that Certified Nurse Aides were turning the call lights off and leaving the rooms and further stated they had talked to them about it until they were blue in the face. Registered Nurse #1 stated they had heard Certified Nurse Aides say that they are not their aide to residents and had received complaints from residents about it. They stated that prior to the Department of Health coming for survey, they started educating Certified Nurse Aides on customer service and caring for residents with dementia. They stated some Certified Nurse Aides did not had proper training and were in the process of re-educating them. Resident #61: Resident #61 was admitted to the facility with diagnoses of displaced fracture of greater trochanter of right femur (fracture of upper part of thigh bone), multiple myeloma (cancer that forms in a type of white blood cell), and unspecified heart failure (a condition where the heart is not pumping effectively). The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, was able to make themselves understood and understood others. The undated Certified Nurse Aide instructions for resident's care report, documented Resident #61 was independent for personal hygiene and toilet use. During an interview on 4/30/2025 at 12:26 PM, Resident #61 stated that one night they accidentally defecated in their brief. They stated three (3) Certified Nurse Aides came into the room and were discussing how there was shit on their balls. Resident #61 stated It made them feel like they were not a patient and should not be afforded sensitivity. They stated, I was just an object, not a human being. The resident stated the staff acted like they had received no training at all. During an interview on 5/08/2025 at 11:30 AM, Licensed Practical Nurse #2 stated staff should never discuss the care that they are providing in a manner that was disrespectful. They stated they should always provide care with dignity and respect. They stated they would talk to the resident to see if they wanted to file a formal grievance so the facility could identify the staff involved. They further stated they had been educating staff on dignity and respect. Resident #265: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #265 was admitted to the facility with diagnoses of pyogenic arthritis (serious and painful infection of a joint), need for assistance with personal care, and acute embolism and thrombosis of unspecified deep veins of right lower extremity (blockage in leg arteries caused by a blood clot). The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The undated Certified Nurse Aide instructions for resident's care report, documented Resident #265 was totally dependent on staff for toilet use. There was a note that there was an immobilizer on the left knee and their knee was to stay extended at all times. The resident required a bedpan, and staff were to prompt and encourage toilet use every two (2) to three (3) hours while awake and as requested during hours of sleep. During an interview on 5/01/2025 at 8:42 AM, Resident #265 was crying and stated there was a time during the evening when they needed to have a bowel movement and were given the bedpan. They stated they were not able to move their bowels and a short time later, requested the bedpan again. The resident stated that the Certified Nurse Aide told them in a sarcastic tone, well, we helped you before and you did not do anything. The resident told the surveyor they could not deal with the sarcasm and had asked a staff member on the night of 4/30/2025, 'what have I done to you to make you respond to me that way?' They stated the Certified Nurse Aide refused to give them the bedpan, and they ended up having a bowel movement in the bed. Resident #265 stated, That goes against everything in my psyche. They stated they tried to tell them that they were not able to lift themselves onto the bed pan and it pulled their skin, and it hurt. They stated they just wanted to be treated fairly. They stated if staff had comments, they should reserve them for themselves, as they needed their most basic needs met-to be washed and toileted. The resident stated, 'what does it cost to be kind? The humiliation is, you as a resident are already down, and they are making it worse.' During an interview on 5/08/2025 at 11:30 AM, Licensed Practical Nurse #2 stated Resident #265 should have received a bedpan when requested. They stated they had received a lot of complaints about evening and night shift staff and had been trying to identify and educate the staff involved. They stated they would talk to the resident about filing a formal grievance so that the facility could identify and educate staff. 10 New York Code of Rules and Regulations 415.5(a)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews conducted during a recertification and abbreviated survey (Case #NY00371796), the facility did not ensure it consulted with the resident ' s physician and notified the resident ' s representative when there was a significant change in the resident ' s physical status for two (2) (Resident #s 61 and 10) of two (2) residents reviewed. Specifically, (a) the facility did not immediately notify the provider on 2/19/2025, when Resident #61 developed new wounds on the left leg. The changes in the resident ' s condition were documented in the Nurse Practitioner communication book and were not reported to the provider until 3/04/2025; and (b) for Resident #10, the resident ' s representative was not notified on 1/25/2025, when there was a significant change in the resident ' s physical status and a new order for treatment which included administration of TobraDex ointment (treats bacterial eye infection) for conjunctivitis (or pink eye; very contagious intection that causes the white of the eye to turn pink or red due to inflammation). This is evidenced by: Cross-referenced to F684: Quality of Care Cross-referenced to F656: Develop/Implement Comprehensive Care Plan The Policy and Procedure titled, Change in a Resident ' s Condition or Status, reviewed/revised 5/14/2022, documented the facility shall promptly notify the attending physician and representative of changes in the resident ' s medical/mental condition and/or status. The charge nurse or designee manager would notify the resident ' s attending physician or on-call physician when there was a significant change in the resident ' s physical/emotional/mental condition. Unless otherwise instructed by the resident, the charge nurse or designee would notify the resident ' s next-of-kin or representative when there was a significant change in the resident ' s physical/emotional/mental condition. Except in medical emergencies, notifications would be made within twenty-four (24) hours of a change occurring in a resident ' s medical/mental condition or status. Regardless of the resident ' s current mental or physical condition, the charge nurse or designee inform the resident of any changes in his/her medical care or nursing treatments. The nurse manager/charge nurse would record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status. Resident #61: Resident #61 was admitted to the facility with diagnoses of displaced fracture of greater trochanter of right femur (fracture of upper part of thigh bone), multiple myeloma (cancer that forms in a type of white blood cell), and unspecified heart failure (a condition where the heart is not pumping effectively). The Minimum Data Set (an assessment tool) dated 5/1/2025, documented the resident was cognitively intact, was able to make themselves understood and understood others. There was no care plan for the resident ' s left leg wounds until 4/17/2025. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Care Note dated 2/13/2025 by Physician Assistant #1, documented the resident had an unmeasurable vascular wound (caused by poor circulation in the arteries or veins) on the left lower extremity. The wound bed was 20 percent eschar (collection of dry, dead tissue within a wound) and 80 percent epithelial (refers to the epidermis, the outermost layer of skin, as it regenerates and covers a wound ' s surface). There was moderate drainage. The periwound (skin surrounding a wound) was intact. Nursing Progress Note dated 2/19/2025 at 11:19 PM, documented that upon examination, the nurse observed that the area in question (left leg) was very red and exhibited pitting edema (occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit or indentation will remain). The resident had decreased sensation in the affected area. Additionally, there were multiple blisters present, one of which was open. The supervisor was promptly notified of the findings. The area was cleaned thoroughly with soap and water, ensuring all debris was removed. The cleaned area was then dried gently to prevent further irritation. The resident did not exhibit any immediate signs of discomfort during the treatment process. The nurse was placing a note in Nurse Practitioner communication book. Review of the Nurse Practitioner communication book on 5/08/2025, documented an undated handwritten note for Resident #61: left leg open blisters. Treatment plan needs to be modified. Refer to note. Pitting edema. Nursing Progress Notes dated 2/20/2025 to 3/3/2025, did not document the provider was notified of the resident ' s new left legs wounds. Review of Wound Care Notes dated 2/20/2025 and 2/27/2025, did not document any new wounds on the resident ' s left leg that were noted by the nurse on 2/19/2025. The skin assessment for the wound on the left lower extremity documented the same details of the wound as was previously documented on 2/13/2025. Nursing Progress Note dated 3/4/2025 at 8:27 AM by Licensed Practical Nurse #2, documented left leg redness. Blisters noted intact at this time. Licensed Practical Nurse #2 would have Nurse Practitioner #1 evaluate today. Resident #61 was encouraged to elevate lower extremity. Would continue to monitor. Progress Note dated 3/4/2025 at 12:52 PM by Nurse Practitioner #1 documented they were asked to see the resident for drowsiness, increased left lower extremity redness and drainage. Per the nurse manager, the resident had increased drowsiness and lower extremity wounds appeared worse despite treatments. Resident #61 stated, I will be better in a couple days. Vital signs were reviewed and stable. The resident had no complaint of pain. Physical exam of the skin documented bilateral lower extremity chronic skin changes, left lower ankle wound, positive odor, purulent drainage, erythema (redness), edema. Neurological documented positive sensation to extremities. Assessment documented lower extremity cellulitis and intravenous antibiotics were ordered to be given daily x5 days. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/08/2025 at 2:10 PM, Nurse Practitioner #1 stated they recalled seeing the resident numerous times for infection. They did not recall being notified on 2/19/2025. They stated if there was a nursing concern, Nurse Practitioner #1 would address it especially if it was cellulitis (a common and potentially serious bacterial skin infection). They stated that on 2/19/2025, the nurse could have called the on-call provider and said the nurses usually documented non-urgent matters in the Nurse Practitioner communication book. They reviewed the progress notes written on 3/04/2025 and stated they started treating the resident for cellulitis at that time. They asked the surveyor if they could look at the Nurse Practitioner communication book and stated there was an undated note about Resident #61. The left leg had open blisters, and the treatment plan needed to be modified; refer to note; pitting edema. They stated there was a wound care notes dated 2/20/2025 and 2/27/2025, from Physician Assistant #1 who saw the resident for weekly wound care. They stated there was nothing in the notes about the change in condition and there was no recommendation for treatment orders documented in the notes. They stated Physician Assistant #1 would make recommendations for orders and then medical would approve or deny them. During an interview on 5/08/2025 at 2:22 PM, Licensed Practical Nurse #2 stated the nurse who worked on 2/19/2025, should have called the doctor if the resident was questionable for cellulitis. They stated that even if they did not recognize what it could be, it was still a change in condition that needed to be reported to the doctor. They stated, ' If you are going to write a note, call the doctor. ' They stated the nurse should have called the on-call provider because it was found during the evening shift. They stated it was not something that should be written in the Nurse Practitioner book because the book was used for communication, not for a solution. During an interview on 5/08/2025 3:36 PM, Assistant Director of Nursing #1 reviewed the nursing notes in the electronic medical record. They stated Nurse Practitioner #1 saw the resident early in the day on 2/19/2025, and then a blister was noted on the night shift. They stated the resident was not seen by medical until 3/4/2025. They stated they did not agree with the nurse placing a note in the Nurse Practitioner book for that type of a change in condition because Resident #61 had wounds on their legs, weeping edema (occurs when fluid leaks out of the skin due to severe swelling), blistery and sometimes opened. They stated they should have called the Nurse Practitioner that was on-call 24/7 and obtained a treatment order. They would expect the nurse to also note the change in condition on the 24-hour report so that the fulltime Nurse Practitioner could see the resident. They stated Physician Assistant #1 would make recommendations for orders and would tell Nurse Practitioner #1 directly. They stated the resident's legs were in a constant state of change and said they had seen the redness on the residents but did not recall the exact date. Resident #10 Resident #10 was admitted to the facility with a diagnosis of type (two) 2 diabetes (a chronic condition that happens when a person has persistently high blood sugar levels), chronic obstructive pulmonary disease (narrowing of airways in the lungs making it difficult to breathe) and chronic atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). The Minimum Data Set, dated dated dated [DATE] documented Resident #10 had intact cognition, was able to make themselves understood, and was able to understand others. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Progress Note dated 1/25/2025, documented Resident #10 appeared to have conjunctivitis of the right eye. The right eye had yellow discharge that was crusty. There was mild scleral erythema (redness in the white of the eye), no edema. Assessment and plan included: Right eye conjunctivitis. Order received to start TobraDex ophthalmic suspension 0.3 percent-0.1 percent to the right eye. One to two (1-2) drops to the right eye every 6 hours once a week. Notify medical for any change in condition. Physician order dated 1/25/2025 documented Resident #10 was to be given TobraDex 0.3- percent-0.1 percent eye ointment. Apply two (2) drops by ophthalmic (eye) route in right eye four (4) times per day for seven (7) days for conjunctivitis. The electronic medical administration record for 1/2025 documented administration of TobraDex eye ointment was initiated on 1/25/2025. There was no documentation in Resident #10 ' s electronic medical record that indicated Resident #10 ' s representative was informed of the change in condition for Resident #10 and the need to initiate treatment that included the administration of Tobradex eye ointment. Nursing progress note dated 2/01/2025 documented Resident #10 completed TobraDex. No complaint of pain or discomfort at this time. Monitoring. There was no documentation in Resident #10 ' s electronic medical record that indicated Resident #10 ' s representative was informed of the change in condition for Resident #10 and the need to initiate treatment that included the administration of Tobradex eye ointment. During an interview on 5/8/2025 at 12:20 PM, Registered Nurse #1 stated when a resident had a change in status, they called the resident ' s representative or spoke to the representative if the representative was in the building in order to notify them of the change in the resident ' s status. They stated they documented the representative was made aware of the change in status in a progress note if they can remember to document it. They stated the representative for Resident #10 was not notified of the change in the resident ' s condition on 1/25/2025, nor were they notified of the initiation of treatment with TobraDex eye ointment. During an interview on 5/08/2025 at 12:51 PM, Director of Nursing #1 stated staff should follow the policy whenever there is a change in resident status. When a change in resident status occurred, the resident ' s representative should have been notified. They further stated that when the resident representative was contacted regarding a change in status, it should have been documented in a progress note. 10 New York Code of Rules and Regulations 415.3(e)(2)(ii)(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 21414 Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (Case #s NY00353853, NY00355929, NY00356190, and NY00357360), the facility did not provide effective housekeeping and maintenance services on two (2) of two (2) resident units. Specifically, floors, walls, ceilings and tables were not clean or maintained. This is evidenced by: During observations on 5/05/2024 at 10:00 AM, the second-floor unit corridor floors were sticky when walked upon. During observations on 5/06/2025 from 10:17 AM through 1:49 PM: 1) The floors in the following areas were soiled with dirt or grime next to walls and/or in corners: 1a- Resident room #s 171, 173, 175, 177, 180, 189, 191, 199, 201, 203, 220, 305, 326, 328, 334, 338, 340, 342, 344, 346, 348, 402, 404, 406, 408, 410, 422, 418, 416, 414, 424, 426, 428, 430, 434, 436, 438, and 440. 1b- First Floor Unit and Second Floor Unit corridors including door thresholds. 1c- First Floor Unit Soiled Holding Room. 1d- Second Floor Unit, east corridor, Soiled Holding Room and Mechanical Room. 1e- Main dining room including behind the vending machines. 1f- Lobby. 1g- Elevator door tracks. 1h- Employee break room. 2) Wallpaper or gypsum board was peeling, walls were scraped, or walls had unpainted sections from wall repairs in resident room #s 173, 222, 310, 318, 326, 336, 338, 340, 342, 348, 402, 404, 414, 416, 418, 424, 426, 428, 430, 432, 434, 436, 438, 440, and 442, and First Floor Unit and Second Floor Unit corridors. 3) Old hollow wall anchors, screws, or small holes were found in the walls in resident room #s 167, 171, 173, 175, 177, 185, 222, 226, 322, 324, 328, 334, 336, 340, 342, 348, 402, 404, 406, 416, 418, 422, 426, 428, 430, 434, 436, 438, and 442. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) Ceiling tiles were stained in resident room #s 173, 175, 177, 197, 207, 209, 226, 404, 406, 408, and 410; the resident room [ROOM NUMBER]/218 bathroom; and the employee break room. 5) The finish on overbed tables, wardrobes, nightstands, or chest of drawers was worn, chipped, or peeling in resident room #s 185, 199, 216, 222, 316, 318, 322, 324, 336, 340, 348, 402, 404, 406, 414, 418, 426, 432, and 434. 6) Other environmental findings: 6a- A wash basin under sink with old stagnant water in room [ROOM NUMBER]. 6b- The room [ROOM NUMBER]/218-bathroom sink had Out of Order sign and plastic covering the sink. 6c- The mirror mounting hardware was broken in room [ROOM NUMBER]. 6d- The toilet and handwashing sink were not working in room [ROOM NUMBER]. 6e- The underside of tables and the sink were soiled with food particles or grime in the main dining room. 6f- During observations on 5/06/2025 at 3:53 PM, the privacy curtain in resident room [ROOM NUMBER] was stained along the bottom. During an interview on 5/06/2025 at 1:20 PM, Resident #6 and Resident #64 in room [ROOM NUMBER] both stated that the toilet and handwashing sink were in disrepair for about one week. During an interview on 5/07/2025 at 3:01 PM, Director of Maintenance #1 stated that they had a plan to strip and wax all corridor floors and that they would address the issues found regarding the walls, stained ceiling tiles, furniture, areas of disrepair, and stained privacy curtains. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during a recertification and abbreviated survey (Case #s NY00344251 and NY00355131), the facility did not ensure residents were free from abuse and neglect for three (3) (Resident #s 48, 78, and 416) of nine (9) residents reviewed. Specifically, (a.) Resident #416, who was a two (2)-person maximum assist with mechanical lift for transfers, was transferred by two (2) Certified Nurse Aides via stand pivot on 6/04/2024. Resident #416 was reportedly lowered to the floor during the transfer from chair to bed and later that evening diagnosed with a left femur (leg bone) fracture. (b.) Resident #48, who was known to have aggressive behaviors, struck Resident #78 on their eye while grabbing a personal item from Resident #78 on 9/22/2024. This resulted in actual harm for Resident #416 that was not Immediate Jeopardy. This is evidenced by: 43805 The facility's Policy and Procedure titled, Abuse Prevention and Reporting, last revised 4/2024, documented that all residents would be treated with respect and dignity, with self-determination and freedom from abuse, mistreatment, neglect and misappropriation of property. The purpose was to protect all residents and provide a safe environment. Abuse was defined as inappropriate physical, verbal or mental contact which harms or was likely to harm a resident. Examples included hitting, pinching, kicking, shoving, sexually molesting, belittling, teasing, ignoring, and embarrassing by either actions or words. Neglect was defined as failure to provide timely, consistent, safe, adequate, and appropriate services such as nutrition, medication, therapy, clean clothing and surroundings, and activities of daily living. 48615 Resident #416 Resident #416 was admitted to the facility with diagnoses of hemiplegia (paralysis of one side of the body) following a cerebral infarction (disrupted blood flow to the brain), Parkinson's Disease (a movement disorder of the nervous system that worsens over time), and muscle weakness (when muscles aren't as strong as they should be). The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood and was able to understand others. The Comprehensive Care Plan titled, Activities of Daily Living, last revised 4/16/2024, documented shower transfer dependent - assist of two (2) person mechanical lift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The Facility's Investigative Report dated 6/05/2024, documented Certified Nurse Aide # 2 and #3 attempted to transfer Resident #416 from the bed to a chair using a stand pivot technique along with the use of a walker. Resident's legs gave way and was lowered to the floor. Resident was sent to the hospital and diagnosed with left distal femur fracture (broken hip). Administrator #1 documented that it was unclear where and when the resident sustained hip fracture. It further documented Certified Nurse Aides were suspended until the investigation was completed due to possible failure to follow the resident's care plan. Certified Nurse Aide #2 statement documented family insisted resident get out of bed for a shower. They looked in resident's closet for the care card (Certified Nurse Aide's instructions for the resident's care) and did not see it available. They stated Certified Nurse Aide #3 assured them they were familiar with Resident #416, and they proceeded with two (2) person stand pivot transfer. Resident #416 immediately began to yell that their legs were hurting. Resident #416 lost their balance and was lowered to the floor. Certified Nurse Aide #3 statement documented they came to assist Certified Nurse Aide #2 to get Resident #416 out of bed and into their wheelchair. They stated the resident would usually stand and get into the chair, and that staff would need to be patient with the resident during the transfer. They further wrote that they stood resident up from the bed, the resident had taken a few steps away from their bed, the resident's legs were really weak, and then the resident was lowered to the floor. Certified Nurse Aide #3 wrote that they were told the resident was a mechanical lift for transfers but could be a two (2) person assist stand pivot. They stated they did not check the care card in the resident's closet. Progress note dated 6/04/2024 at 7:17 PM written by Registered Nurse #4, documented that upon entering the resident's room, the resident was lying on the floor alongside the bed. Resident appeared out of their norm, vital signs: blood pressure 84/68, skin was pale, neurological assessment was within normal limits. The resident was assisted off the floor via mechanical lift. Family insisted on sending resident to hospital for further evaluation, 911 was called and resident transferred to hospital. Hospital progress note dated 6/07/2024, documented resident was brought to the hospital on 6/03/3024 with a reported history of hypoxia (low levels of oxygen in your body tissues) and hypotension (low blood pressure). They were admitted with diagnosis of severe sepsis with shock (infection in your body causing extremely low blood pressure and organ failure), and distal left femur fracture (broken long bone of the leg) due to a mechanical fall (an external force that caused the patient to fall and/or that there is no underlying pathology of concern and/or the patients did not pass out first). Orthopedic Surgery note dated 6/08/2024 documented x-ray left femur (hip) moderately displaced comminuted distal femoral fracture (the bone in the thigh was broken into multiple pieces and the pieces were out of alignment). Resident #416's Care Kardex (resident care instructions for the Certified Nurse Aides) dated 5/30/2024, documented chair to bed transfer, dependent (with two (2) staff members to assist), mechanical lift. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/06/2025 at 12:57 PM, Assistant Director of Nursing #1 stated that on 6/03/3024, Certified Nurse Aide #s 2 and 3 attempted to transfer Resident #416 from the bed to a chair with a two (2)-person stand pivot and, in the process, the resident was lowered to the floor. Later, the resident complained of intense pain and was sent to the hospital. Assistant Director of Nursing #1 stated Certified Nurse Aide #2 was terminated for failure to follow the resident's care plan. During an interview on 5/06/2025 at 1:30 PM, Director of Rehabilitation #1 stated Resident #416 was well known to the therapy department as requiring full assistance with two (2) staff members for mechanical lift transfers. Rehabilitation Director #1 stated Certified Nurse Aide #2 was terminated for failure to follow the resident's care plan. Resident #48 Resident #48 was admitted to the facility with diagnoses of diabetes type 2 (when the body cannot use insulin or produce enough insulin), dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool) dated 11/05/2024, documented the resident had moderate cognitive impairment, could be understood and understand others. The Comprehensive Care Plan focus area titled, Resident had Potential to be an Aggressor Related to Mental Illness, dated 9/23/2024, documented interventions including administer medications as ordered, analyze key times, places, circumstances, triggers and what de-escalates behavior, assess and anticipate resident needs; and monitor resident closely when they were around other residents. Record review of psychiatric consultation note dated 9/07/2024, documented Resident #48 was easily annoyed, and resident admitted to picking/choosing medications to take. Resident had limited cooperation, poor insight, low concentration and attention. Consider increase Risperdal one (1) milligram twice daily. Resident #78 Resident #78 was admitted to the facility with diagnoses of aphasia (difficulty speaking), cerebral infarction (disrupted blood flow to the brain), and apraxia (when a person is unable to perform tasks or movements when asked). The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment, could be understood and understand others. The facility Investigative Summary dated 9/22/2024 at 7:30 PM, documented Resident #78 reported to Registered Nurse #2 that while sitting in the hallway near the nurse's station, Resident #48 struck them in the eye. They were complaining of eye swelling. Upon assessment, Resident #78 had mild edema (swelling) to right eye but no abrasions, discolorations or lacerations (cuts). Resident #78 was tearful but later calmed down after speaking with family. Resident #48 denied ever striking Resident #78. It further documented there were no witnesses to the incident despite it occurring in the hallway. It documented Licensed Practical Nurse #3 reported Resident #48 had been agitated and experiencing hallucinations over the past few weeks with psychiatry following. Resident #48's psychotropic medications were adjusted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility reported incident report, submitted to the Department of Health on 9/22/2024, indicated Resident [#48], struck Resident [#78] with a closed fist on the right eye. During an interview on 4/30/2025 at 1:55 PM, Licensed Practical Nurse #2 stated on 9/22/2024, Resident #78 sat at the nurse's station and Resident #48 was standing there as well and there was confusion about a personal item. Resident #48 wanted the item and took it from Resident #78. Residents #48 and #78 were separated and assessed. During an interview on 4/30/2025 at 2:58 PM, Registered Nurse #2 stated Resident #48 had a long psychiatric history, and they were very impulsive, but they did not recall them hitting anyone else. During an interview on 4/30/2025 at 3:10 PM, Licensed Practical Nurse #6 stated Resident #48 wandered about the unit most of the day including in and out of other resident rooms. Resident #48 was difficult to redirect and would start to use profanity when redirected. Resident #48 had attempted to hit staff. During an interview on 05/08/2025 at 11:49 AM, Director of Nursing #1 stated they were not employed at this facility at the time of the incident. They were aware of resident #48's behaviors and that they were followed by psychiatry. Staff on second floor are also aware resident #48's behavior and try to keep resident in high visible areas where they can be monitored close. During an interview on 05/08/2025 at 12:23 PM, Administrator #1 stated they were only at this facility a few months and not the administrator at time of the incident. They deferred all clinical discussions to Director of Nursing #1. Administrator #1 stated all allegations of abuse and or neglect are reported to the Department 10 New York Code of Rules and Regulations 415.4 (b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48615 Based on record review and interview conducted during the Recertification and Complaint Survey (NY00355131 and NY00349007), the facility did not report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action was taken. This was evident in three (3) (Resident #48, #78 and 416) out of seven (7) residents reviewed for abuse and neglect. Specifically, Resident #48 struck Resident #78 in the face while grabbing a personal item from Resident #78. Resident #416 ' s transfer status was two-person maximum mechanical lift; two Certified Nurse Aides transferred resident via stand pivot on 6/03/2024. Resident #416 was lowered to floor during the transfer from chair to bed and later that evening diagnosed with a femur (leg bone) fracture. This is evidenced by: Cross-referenced to F600: Free from Abuse and Neglect The facility ' s Policy and Procedure Titled, Abuse Prevention and Reporting, last revised 4/2024, documented, the purpose is to protect all residents and provide a safe environment. Abuse is defined as inappropriate physical, verbal or mental contact which harms or is likely to harm a resident. Upon receiving a report of suspicion of abuse of any kind, mistreatment, neglect or misappropriation of property, supervisory/administrative staff are required to immediately initiate an investigation into the alleged incident. iv. All abuse investigations will be reviewed by the Administrator, Medical Director and Director of Nursing. v. Determination of validity of report must be made in the most-timely fashion possible in order to comply with reporting requirements as stated in the most current version of the Incident Reporting Manual (August 2016 as of this writing) vi. If deemed a reportable incident, reporting of the incident is to be made in accordance with the requirements stated in manual for specific incident. Reference appended table for categories of incidents and reporting time frame requirements. vii. Notification is to be made to local police authorities as well as the Attorney General ' s Office as appropriate. Resident #48 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #48 was admitted to the facility with the diagnoses of Diabetes type 2 (when the body cannot use insulin correctly and sugar builds up in the blood); Dementia (loss of the ability to think, remember, and reason to levels that affect daily life and activities); and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool) dated 01/28/2025, documented the resident was able to be understood and was able to understand others with moderate cognitive impairment. Resident #78 Resident #78 was admitted to the facility with the diagnoses of Aphasia (a disorder that affects how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written) following cerebral infarction (disrupted blood flow to the brain), and apraxia (when a person is unable to perform tasks or movements when asked). The Minimum Data Set (an assessment tool) dated 03/20//2025 documented the resident was able to be understood and was able to understand others with moderate cognitive impairment. The Comprehensive Care Plan dated 9/23/2024 with focus: Resident #48 has potential to be an aggressor related to mental illness. Interventions include: (1) Administer medications as ordered. (2) Analyze key times, places, circumstances, triggers and what de-escalates behavior. (3) Assess and anticipate resident needs (4) Monitor residents closely when they are around other residents. The facility Investigative Summary dated 9/22/2024 documented an alleged resident to resident altercation between Resident #s 48 and 78. Specifically that Resident #48 struck Resident #78 in the face while grabbing a personal item from Resident #78. The summary with conclusion was signed by Assistant Director of Nursing Services #2 on 9/22/2024. There was no documented evidence the facility reported the results of the investigations to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation was verified appropriate corrective action was taken. During an interview on 04/30/2025 at 10:30 AM, Director of Nursing #1 stated they did not have the Investigative File for review. The previous administrator did not leave the file where it could be located. They would have to recreate the file. Resident #416 Resident #416 was admitted to the facility with the diagnoses of right hemiplegia (paralysis of one side of the body) following a cerebral infarction (disrupted blood flow to the brain); Parkinson ' s Disease (a movement disorder of the nervous system that worsens over time), and Muscle Weakness (when muscles aren't as strong as they should be). The Minimum Data Set (an assessment tool) dated 5/30/2024, documented the resident was able to be understood and was able to understand others with severe cognitive impairment. The Comprehensive Care Plan Titled Activities of Daily Living revised 4/16/2024, documented shower transfer - dependent (assist of two (2)) mechanical lift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing progress note dated 6/4/2024 documented, upon entering resident ' s room resident was lying on the floor alongside bed. Resident appeared out of their norm, vital signs were blood pressure 84/68, pallor noted, Neurological assessment were within normal limits; lower extremities could not be assessed. Resident was assisted off of floor via Hoyer lift. Family insisted on sending resident to hospital for further evaluation, 911 was called and resident transferred to hospital. The Nursing Home Facility Incident Report was submitted by Administrator #2 on 6/4/2024 at 10:07 AM to the State Survey Agency. There was no documented evidence the facility reported the results of the investigations to the State Survey Agency, within 5 working days of the incident, and if the alleged violation was verified appropriate corrective action was taken. During an interview on 5/08/2025 at 11:30 AM, Assistant Director of Nursing #1 stated the administrator handled the entire investigation and they did not have any part of investigation or reporting. During an interview on 5/08/2025 at 11:49 AM, Director of Nursing #1 stated they were only in this position for three weeks; they were unaware of what took place regarding the investigation. They stated they believed a Certified Nurse Aide was terminated due to failure to follow care plan. They further stated that they were aware completed investigations are to be submitted results to the New York State Department of Health agency within five (5) days. During an interview on 5/08/2025 at 12:23 PM, Administrator #1 stated they had only been serving as administrator at this facility for a short time, that there were two previous administrators at the facility for a short time and some things were not filed as they should have been. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on record review and interviews conducted during a recertification survey, the facility did not ensure the facility conducted initially and periodically comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity and completed not less than once every 12 months for two (2) (Resident #s 28 and 415) of 32 residents reviewed for Comprehensive Resident Assessments. Specifically, (a) for Resident # 28, the Comprehensive Resident Assessments were not completed to assess the patient's edema, and (b) for Resident #415, the Comprehensive Resident Assessments were not completed to assess items from their baseline care plan. This is evidenced by: Cross reference to F656: Develop/implement Comprehensive Care Plan A facility's undated policy and procedure titled Comprehensive Care Plans documented that the assessment must accurately reflect the resident's status and be reflective of the resident's state at the time of assessment. A comprehensive care plan will be developed within seven (7) days after completion of the comprehensive assessment and address specific care areas (focuses) as identified therein, as well as those deemed appropriate through resident interview or other data sources. Resident #28 Resident #28 was admitted with the diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling, irritation, and inflammation inside the airways that limit airflow into and out of the lungs), chronic ischemic heart disease (a long-term reduction in blood flow to the heart muscle, often due to coronary artery disease), and cellulitis (a common bacterial skin infection that causes pain, redness, swelling, and warmth in the affected area). The Minimum Data Set, dated dated dated [DATE], documented that the resident was usually understood and could sometimes understand others and required extensive assistance for most activities of daily living. A review of Resident #28 Minimum Data Set conducted on 4/11/2025 did not indicate that the resident had edema as described in their baseline care plan. A review of Resident #28 Medication Administration Record and Treatment Administration Record for May 2025 did not have any documentation addressing the resident's edema or cellulitis. A review of Resident #28's Comprehensive Care Plan had no interventions for the resident's edema or cellulitis. During an interview on 5/01/2025 at 10:57 AM, Resident #28 was observed sitting on the edge of their bed and had severely edematous legs. Resident #28 was asked what the facility did to help them with their legs, and they stated that the facility did nothing for them. The resident stated that sometimes the legs weep, and that staff would occasionally wrap them, but not very often. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/2025 at 11:46 AM, Registered Nurse #3 stated that there should have been an assessment and plan for residents' edema and cellulitis, and did not know why there was none. They stated that there should have been interventions listed for these issues in the comprehensive care plan, as well as the medication administration and treatment administration records. Resident #415 Resident #415 was admitted to the facility with the diagnoses of dementia (a generative neurological disease which causes memory issues), type 2 diabetes mellitus (an endocrine dysfunction causing unregulated blood glucose levels), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool), dated 3/11/2025, documented that the resident was able to be understood and understood others, with severe cognitive impairment. The baseline care plan, dated 1/24/2025, documented the following: Resident is at risk for/has skin impairment due to: . Resident ' s significant medical diagnoses include:. Resident is admitted on antibiotics for continued treatment of:. Resident has intravenous/dialysis/chemotherapy port present at {site} on admission. Resident ' s significant mental health diagnoses include:. Resident need Total/Ext/Limited/Supervision support of [3] staff to complete activities of daily living. Resident has history of constipation/obstruction:. Resident is on special diet of:. Resident is at risk for pain/is on pain management due to:. Resident is at risk for elopement as evidenced by:. Resident has expressed significant religious/cultural preferences:. Resident has an ostomy. There were no documented responses to any of the above prompts in the baseline comprehensive care plan. There was no documented evidence that Resident #415 had an ostomy. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan for skin integrity dated 1/24/2025 documented that the resident had a rash on their buttock to be treated with {insert medication} for {duration}. The goal documented that the rash would not worsen and show signs of improvement. The interventions documented to apply local treatment, monitor for infection, report worsening condition, use an air cushion when in the [NAME] lounger, and float the resident ' s heels. There was no documentation that the resident was at risk for developing pressure sores. The comprehensive care plan for psychosocial well-being, dated 1/24/2025, documented the resident would be provided emotional support, assistance with activities of daily living, nutrition, and hydration. There was no documentation regarding an ostomy. The comprehensive care plan for nutritional status dated 1/24/2025 documented that the resident was to tolerate their diet and maintain weight with 75 percent of their intake. There was no documentation regarding an ostomy. During an interview on 5/08/2025 at 10:38 AM, Registered Nurse #1 stated they worked on the care plans but were severely in need of help. Registered Nurse #1 stated that they were told they would receive an assistant last year, but it had not happened. Registered Nurse #1 stated that they worked passing medications, acted as an aide, and spent most of their time working to provide resident care on the unit. 10 New York Code of Rules and Regulations 415.11(a)(2)

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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 43805 Based on a record review and staff interviews conducted during a recertification survey, the facility did not ensure that Preadmission Screening was complete for two (2) (Resident #s 31 and 103) of the 32 residents reviewed. Specifically, an accurate Preadmission, Screening and Resident Review (PASARR) was not completed or corrected. This is evidenced by: The Policy and Procedure for Admission Screening and Approval Process for Long Term Care (New York State) documented the admission process to the facility from a hospital or other health facility. A qualified Registered Professional Nurse assessor must complete a Patient Review Instrument, and the Preadmission Screening must be completed and signed by a qualified assessor. Resident #31 Resident #31 was admitted to the facility with the diagnoses of bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, ranging from periods of mania or hypomania to periods of depression), chronic obstructive pulmonary disease (term for certain types of irreversible lung and airway damage that obstruct your airways and make it hard to breathe), and hyperlipidemia (a condition characterized by elevated levels of lipids, or fats, in the blood). The Minimum Data Set (an assessment tool) dated 4/29/2025 documented that the resident could be understood, understand others, and was cognitively intact. The review of the Preadmission Screening and Resident Review Assessment documented that the assessment was completed on 11/19/2024 and signed by a Registered Nurse performing the evaluation. The assessment documented that Resident #31 had dementia. There was no documented evidence of a serious mental illness. A review of Resident #31's medical records conducted on 5/01/2025 at 9:39 AM documented that the resident did not have a diagnosis of dementia but did have a diagnosis of bipolar disorder. During an interview on 5/06/2025 at 11:39 AM, Corporate Social Worker #1 stated that admissions did the initial review of the screening assessment before the resident was sent to the facility, and Social Workers were the second level of review. They stated that serious mental illnesses included the diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, panic disorder, and major depressive disorder. They further stated that any serious mental disorder consisted of any that would impair the daily function of the resident. Corporate Social Worker #1 stated that nursing would ensure that the resident's diagnoses were correct and review with the hospital for accuracy before admittance. Corporate Social Worker #1 stated that admissions would review the resident's diagnoses for accuracy, review a list of residents with mental health diagnoses, and make appropriate Level II PASARR referrals. 48413 (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #103 Resident #103 was admitted to the facility with the diagnoses of schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin or can't effectively use the insulin it produces), and dysphagia (medical term for difficulty swallowing that can be a painful condition and in some cases impossible). The Minimum Data Set) dated 3/5/2025 documented that the resident was able to be understood, was able to understand others, and was cognitively intact. The Preadmission Screening and Resident Review assessment was completed on 2/04/2025. There was no documented evidence of a serious mental illness or a referral for Level II services. The Progress notes dated 2/10/2025 documented the resident resided in a group home overseen by the New York State Office of Mental Health. The Progress notes dated 3/20/2025 documented that the resident ' s discharge goal was to return to their mental health housing. The Progress notes dated 3/29/2025 documented that a conference was held with the resident ' s community mental health team, including the housing manager and a case manager from Community Treatment. During an interview on 5/06/2025 at 10:36 AM, Social Worker #1 stated they, themselves, were not licensed to complete the screen form, so they did not have much to do with it. They stated they would consider the diagnosis of schizophrenia as a serious mental illness. They stated they were surprised there was no Level II referral for Resident #103. They stated they had been working with their community housing and mental health team toward a discharge back to the community. During an interview on 05/06/2025 at 11:39 AM, Corporate Social Worker #1 stated that a Level II referral should have been completed after the resident was no longer considered short stay (30 days or less). They stated that a diagnosis of schizophrenia should have triggered the request for a Level II evaluation. They further stated that a list of residents with mental health diagnoses had been compiled, and the appropriate Level II referrals would be made. 10 New York Code of Rules and Regulations 415.11(e)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on observation, record review, and interviews conducted during a recertification and abbreviated survey (case # ' s NY00362000 and NY00379563), the facility did not develop and implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 16 (Residents #s 6, 10, 13, 28, 31, 37, 52, 61, 70, 72, 86, 103, 107, 262, 413, and 415) of 32 residents reviewed for Care Plans. Specifically, (a.) Resident #6 ' s, care plan did not address foot care; (b.) Resident #13 ' s care plan did not include person centered interventions for behavior and diabetes mellitus management; (c) Resident #28 ' s, pain care plan was not implemented for monitoring for effectiveness of administered pain medication; (d) Resident #52 ' s at risk for malnutrition care plan lacked person centered interventions: (e) Resident #61 did not have a care plan to address vascular wounds; (f) Resident #70 ' s care plans for dementia and mood lacked person centered interventions; (g) Resident #72 ' s, care plan was not implemented to prevent the resident from falling; (h) Resident #86 ' s care plans for behaviors lacked person centered interventions; (i) Resident #103 ' s, care plan for abuse prevention lacked interventions; (j) Resident #107, did not have a care plan in place for infections; (k) Resident #262 did not have a care plan to address an abscess; (l) Resident #10, did not have a care plan to address conjunctivitis; (m) Resident #413, did not have a care plan to address the treatment of a pressure ulcer; (n) Resident #415 did not have a care plan to address denture care, or at risk for pressure ulcers, (o) Resident #37 ' s comprehensive care plan was not implemented to reflect the resident's safety concerns regarding other residents entering their room at times, and this issue needed to be addressed by staff, (p) Resident #31 ' s care plan did not include person centered interventions and specific goals for oxygen administration. This is evidenced by: An undated facility policy titled Comprehensive Resident Centered Care Plans documented the care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident ' s strengths, limitations and goals. The care plan will be complete, current, realistic, time specific and appropriate to the individual needs for each resident. A resident ' s care plan should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care. Resident #103 Resident #103 was admitted to the facility with the diagnoses of atrial fibrillation (abnormal heart rhythm), type 2 diabetes, and dysphagia (swallowing disorder). The Minimum Data Set (an assessment tool) dated 3/05/2025 documented the resident could be understood, could understand others, and was cognitively intact. The comprehensive care plan titled Risk for Abuse, initiated 4/26/2025, had no interventions for the focus (Risk for Abuse). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/0/2025 at 10:46 AM, Registered Nurse #1 stated they were responsible for initiating and updating care plans, though other registered nurses could as well, like off shift supervisors. They did not know why there were no interventions listed for this comprehensive care plan. Resident #72 Resident #72 was admitted with the diagnoses of hypertension (high blood pressure), depression (a mood disorder characterized by persistent sadness and loss of interest or pleasure in daily activities), and gastroesophageal reflux disease (when stomach acid flows back up into the esophagus and causes heartburn). The Minimum Data Set, dated dated dated [DATE] documented the resident could be understood, could understand others, and was severely cognitively impaired. 34630 The comprehensive care plan titled Risk for Falls documented the following interventions to be put in place to prevent falls and injury: -bedside mats to floor when in bed -low bed 43805 The Incident and Accident forms dated 3/12/2025 and 3/25/2025 documented the resident fell from bed and the floor mat was not in place. The Incident and Accident form dated 3/18/2025 documented the resident fell from their bed that was left in the high position, rather than the low position as directed by the comprehensive care plan. 48413 The comprehensive care plan titled Behavior Problem: disruptive/dangerous/inappropriate last revised on 4/0/2025 did not include person-centered recommendations to help mitigate or prevent behaviors that could lead to injury. 48744 During an interview on 5/0/2025 at 10:46 AM, Registered Nurse #1 stated they were responsible for initiating and updating care plans, though other registered nurses could as well, like off shift supervisors. They agreed comprehensive care plans should be resident centered. They stated that they had not been aware that interventions on the comprehensive care plan were not flowing automatically to the certified nursing assistant Kardex. They did not know why the resident ' s interventions were not in place, resulting in falls. They stated the low bed for the resident had been ordered and was on back order. 51317 Resident #415 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #415 was admitted to the facility with the diagnoses of dementia (a generative neurological disease which causes memory issues), type 2 diabetes mellitus (an endocrine dysfunction causing unregulated blood glucose levels), and hypertension (high blood pressure). The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood, could understood others, and was severely cognitively impaired. The comprehensive care plan for skin integrity dated 1/24/2025 documented the resident had a rash on their buttock, to be treated with {insert medication} for {duration}. The goal documented the rash would not worsen and show signs of improvement. The interventions documented to apply local treatment, monitor for infection, report worsening condition, use air cushion when in the [NAME] lounger, and to float the resident ' s heels. There was no documentation that the resident was at risk for developing pressure sores. The comprehensive care plan for nutritional status dated 1/24/2025 documented the resident was to tolerate their diet and maintain weight with 75 percent of their intake. The comprehensive care plan for dental care, dated 1/24/2025, did not document the resident had dentures. A nursing note dated 3/06/2025 at 4:04 PM documented Resident #415 had developed a moisture-related redness, and maceration to their buttocks, the area was cleaned and dressed; the family was made aware and a consult with wound care had been placed. There was no update to the care plan to reflect the change in skin condition. A wound care note date created 3/07/2025 and last updated 5/08/2025, documented Resident #415 had a stage 2 pressure sore with no drainage noted on 3/07/2025. The same pressure sore had increased in size and progressed to a stage 3 with moderate drainage by 3/21/2025. On 3/27/2025, the pressure sore was noted to be unstageable, and had decreased slightly in length, but the depth remained the same. There was no documented update to the care plan after each skin assessment. During an interview on 5/8/2025 at 10:08 AM, Licensed Practical Nurse #5 stated if a new pressure area developed, they would immediately call a supervisor for measurements and directives, and the nurse practitioner was there every day and would be told. During an interview on 5/08/2025 at 10:38 AM, Registered Nurse #1 stated they worked on the care plans but were severely in need of help. Registered Nurse #1 stated that they were told they would receive an assistant last year, but it had not happened. Registered Nurse #1 stated that they worked passing medications, acted as an aide, and spent most of their time working to provide resident care on the unit. 10 New York Codes, Rules, and Regulations 415.11 (c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on observations, record reviews, and interviews conducted during a recertification and abbreviated survey (Case #NY00377938), the facility did not ensure that Comprehensive Care Plans were reviewed after each assessment and revised based on the changing goals, preferences, and needs of the resident and in response to current interventions for four (4) (Residents # ' s 13, 37, 97, and 415) of 32 residents reviewed. Specifically, (a) for Resident #13, the resident ' s allergy care plan was not updated to reflect the resident ' s current medication allergies; (b) for Resident #37, the resident ' s comprehensive care plan was not updated to reflect the resident's safety concerns regarding other residents entering their room; (c) for Resident #97, there was no care plan meeting held to review and revise the comprehensive care plan with the resident/resident ' s representative; and (d) for Resident #415, the resident ' s comprehensive care plan was not updated to reflect the resident's pressure ulcers. This is evidenced by: Resident #13 Resident #13 was admitted with the diagnoses of fracture of the right femur (a break in the long bone of the leg), end-stage renal disease (a condition where the kidneys can no longer effectively filter waste and excess fluid from the blood), and type 2 diabetes mellitus (an endocrine dysfunction causing unregulated blood glucose levels). The Minimum Data Set (an assessment tool) dated 3/25/2025 documented that the resident was able to be understood, able to understand others, and was cognitively intact. The Comprehensive Care Plan, titled 'Allergy,' last updated on 4/16/2025, listed cholecalciferol as a medication allergy. The Physician's Order, dated 4/15/2025, documented cholecalciferol 125 micrograms in a capsule to be administered orally once daily. A review of the Medication Administration Record for April 2025 and May 2025 documented that the resident had received this medication. During an interview on 5/06/2025, at 10:46 AM, Registered Nurse #1 stated that they were responsible for initiating and updating care plans. They indicated that they were not aware of the conflicting allergy care plan. Resident #97 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #97 was admitted to the facility with the diagnoses of chronic respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and congestive heart failure ((a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). The Minimum Data Set, dated dated dated [DATE] documented that the resident was understood, could understand others, and was cognitively intact. A review of the medical record revealed that no care plan meetings had been held since the admission care plan meeting on 11/13/2024. During an interview on 4/03/2025, at 8:37 AM, Resident #97 stated that they had not been invited to a care conference but would like to attend one. During an interview on 5/06/2025 at 10:36 AM, Social Worker #1 stated care plan meetings were held after admission, quarterly, annually, and as needed. They stated the care plans were reviewed and updated as required by the interdisciplinary team. During an interview on 5/08/2025 at 1:15 PM, Social Worker #1 stated they weren ' t aware Resident #97 hadn ' t had a care meeting but would investigate it. 48744 Resident #415 Resident #415 was admitted to the facility with diagnoses of dementia (a generative neurological disease which causes memory issues), type 2 diabetes mellitus, and hypertension (high blood pressure). The Minimum Data Set, dated dated dated [DATE], documented that the resident was able to be understood and understand others, with severe cognitive impairment. The Comprehensive Care Plan for Skin Integrity dated 1/24/2025 documented that the resident had a rash on their buttock to be treated with '{insert medication} for {duration}. ' The goal documented was the rash would not worsen and show signs of improvement. The interventions documented to apply local treatment, monitor for infection, report worsening condition, use an air cushion when in the [NAME] lounger, and to float the resident ' s heels. There was no documented evidence that the resident was at risk for developing pressure sores. A nursing note dated 3/06/2025 at 4:04 PM documented that Resident #415 had developed a moisture-related redness and maceration to their buttocks, that the area was cleaned and dressed; the family was made aware, and a consult with wound care had been placed. There was no documented evidence of an update made to the care plan to reflect the change in skin condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A wound care note dated 3/07/2025 and last updated 5/08/2025, documented that Resident #415 had a stage two (2) pressure sore with no drainage noted on 3/07/2025. The same pressure sore had increased in size and progressed to a stage 3 with moderate drainage by 3/21/2025. On 3/27/2025, the pressure sore was noted to be unstageable and had decreased slightly in length, but the depth remained the same. There was no documented evidence of an update to the care plan after each skin assessment. During an interview on 5/08/2025 at 10:38 AM, Registered Nurse #1 stated they worked on the care plans but were severely in need of help. Registered Nurse #1 stated that they were told they would receive an assistant last year, but it hadn ' t happened. Registered Nurse #1 stated that they worked the carts, acted as an aide, and spent most of their time working the unit. 10 New York Code of Rules and Regulations 483.21 (b)(2)(iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interview during a recertification and abbreviated survey (Case # ' s NY00348580; NY00355929; NY00348873; NY00351874 and NY00347329), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for four (4) (Resident #s 6, 28, 61, and 262) of 32 residents reviewed. Specifically, (a.) Resident #61 was noted by nursing staff on 2/19/2025 to have signs and symptoms of cellulitis (bacterial skin infection) on the left leg. The facility did not have evidence of monitoring of the resident ' s condition from 2/20/2025 to 3/3/2025; there was no order for periodic skin checks. The resident was not seen by the provider until 3/04/2025 and was diagnosed and treated for cellulitis of the left leg. (b.) Resident #28 was observed with severely edematous (swelling caused by excess accumulation of fluid) legs and the resident reported the facility was not doing anything to treat the condition. (c.) Resident #6 ' s feet were dry, scaly, and peeling, with no documented treatment. (d.) The facility did not administer Resident #262 ' s ace wraps as ordered by the provider. This is evidenced by: Cross-referenced to F580: Notify of Changes Cross-referenced to F636: Comprehensive Assessments & Timing Facility Policy and Procedure titled, Change in a Resident ' s Condition or Status, documented the nurse manager/charge nurse would record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status. The Policy and Procedure titled, Skin Care, Routine Care/Prevention Protocol, reviewed/revised 11/1/2017, documented the purpose of the policy was to maintain skin integrity and prevent tissue breakdown. It documented all residents did not require a physician order unless specialty equipment was required. Procedure included apply named moisturizer to all areas of the skin prone to dryness after bathing. Report reddened areas or skin breakdown to the nurse. Resident #61: Resident #61 was admitted to the facility with diagnoses of displaced fracture of greater trochanter of right femur (fracture of upper part of thigh bone), multiple myeloma (cancer that forms in a type of white blood cell), and unspecified heart failure (a condition where the heart is not pumping effectively). The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, was able to make themselves understood and understood others. Wound Care Note dated 2/13/2025 by Physician Assistant #1, documented the resident had an unmeasurable vascular wound (caused by poor circulation in the arteries or veins) on the left lower extremity. The wound bed was 20 percent eschar (collection of dry, dead tissue within a wound) and 80 percent epithelial (refers to the epidermis, the outermost layer of skin, as it regenerates and covers a wound ' s surface). There was moderate drainage. The periwound (skin surrounding a wound) was intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Progress Note dated 2/19/2025 at 11:19 PM, documented that upon examination, the nurse observed that the area in question (left leg) was very red and exhibited pitting edema (occurred when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit or indentation will remain). The resident had decreased sensation in the affected area. Additionally, there were multiple blisters present, one of which was open. The supervisor was promptly notified of the findings. The area was cleaned thoroughly with soap and water, ensuring all debris was removed. The cleaned area was then dried gently to prevent further irritation. The resident did not exhibit any immediate signs of discomfort during the treatment process. The nurse was placing a note in Nurse Practitioner communication book. Review of the Nurse Practitioner communication book on 5/08/2025, documented an undated handwritten note for Resident #61: left leg open blisters. Treatment plan needs to be modified. Refer to note. Pitting edema. Nursing Progress Notes dated 2/20/2025 to 3/03/2025, did not document Resident #61 ' s change in condition noted on 2/19/2025, was being monitored by nursing staff. Review of orders dated February and March 2025 did not document an order for periodic skin checks. Review of Wound Care Notes dated 2/20/2025 and 2/27/2025, did not document any new wounds on the resident ' s left leg. The skin assessment for the wound on the left lower extremity documented the same details of the wound as was previously documented on 2/13/2025. Review of Daily Medicare Notes dated 2/21/2025, 2/25/2025, 2/27/2025, and 2/28/2025 by Registered Nurse #2, documented the resident had no wounds. Nursing Progress Note dated 3/04/2025 at 8:27 AM by Licensed Practical Nurse #2, documented left leg redness. Blisters noted intact at this time. Licensed Practical Nurse #2 would have Nurse Practitioner #1 evaluate today. Resident #61 was encouraged to elevate lower extremity. Would continue to monitor. Progress Note dated 3/04/2025 at 12:52 PM by Nurse Practitioner #1 documented the following: They were asked to see the resident for drowsiness, increased left lower extremity redness and drainage. Per the nurse manager, the resident had increased drowsiness and lower extremity wounds appeared worse despite treatments. Resident #61 stated, they would be better in a couple days. Vital signs were reviewed and stable. The resident had no complaint of pain. Physical exam of the skin documented bilateral lower extremity chronic skin changes, left lower ankle wound, positive odor, purulent drainage, erythema (redness), edema. Neurological documented positive sensation to extremities. Assessment documented lower extremity cellulitis and intravenous antibiotics were ordered to be given daily for five (5) days. 43805 Resident #28: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28 was admitted with the diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling, irritation, and inflammation inside the airways that limit airflow into and out of the lungs), chronic ischemic heart disease (a long-term reduction in blood flow to the heart muscle, often due to coronary artery disease), and cellulitis (a common bacterial skin infection that causes pain, redness, swelling, and warmth in the affected area). The Minimum Data Set, dated dated dated [DATE], documented that the resident was usually understood and could sometimes understand others, and required extensive assistance for most activities of daily living. During an interview on 5/01/2025 at 10:57 AM, Resident #28 was observed sitting on the edge of their bed and had severely edematous legs. Resident #28 was asked what the facility did to help them with their legs, and they stated that the facility did nothing for them. The resident stated that sometimes the legs weep, and that staff would occasionally wrap them, but not very often. A review of Resident #28's Comprehensive Care Plan had no interventions for the resident's edema or cellulitis. A review of Resident #28 Medication Administration Record and Treatment Administration Record for May 2025 did not have any documentation addressing the resident's edema or cellulitis. During an interview on 5/06/2025 at 11:46 AM, Registered Nurse #10 stated that there should have been an assessment and plan for residents' edema and cellulitis, and did not know why there was none. They stated that there should have been interventions listed for these issues in the comprehensive care plan, as well as the medication administration and treatment administration records. 48413 Resident #6: Resident #6 was admitted to the facility with diagnoses of congestive heart failure, chronic obstructive pulmonary disease, and muscle weakness. The Minimum Data Set (an assessment tool) dated 3/06/2025 documented the resident was able to be understood, was able to understand others, and was cognitively intact. During an observation on 4/29/2025 and 4/30/2025, the resident's feet appeared to be dry, scaly, and peeling. During an interview on 4/29/2025, the resident denied pain. A review of the Medication Administration Record and Treatment Administration Record for March 2025 and April 2025 documented there were no treatments ordered for the resident's feet. A review of the resident's care plan titled At Risk for Skin Breakdown did not address care for the resident's feet. The Medical Provider Order dated 4/28/2025 documented podiatry (foot doctor) consultation as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's medical record showed there were no podiatry visits documented. During an interview on 05/06/2025 at 10:46 AM, Registered Nurse #1 stated there was no order for lotion or foot care for the resident. They stated a new podiatrist would be starting at the facility soon. 10 New York Code of Rules and Regulations 415.12

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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. 48744 Based on record reviews and interviews during the recertification and abbreviated survey (Case #s NY00362000 and NY00377938), the facility did not ensure residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for one (1) (Resident # 413) of two (2) residents reviewed. Specifically, for Resident #413, (a.) treatment for a Stage 2 pressure ulcer was not initiated on 11/04/2024 when an open area was noted on the coccyx until 11/07/2024; (b.) Resident #413 ' s care plan was not updated to include goals, treatments, or interventions related to the discovery of this pressure ulcer; (c.) there was no documented evidence of weekly assessment as recommended on 11/07/2024. This is evidenced by: 51317 The facility policy and procedure titled, Pressure Ulcer Prevention, dated 3/01/2024, documented it was the policy of the facility to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Preparation included reviewing the resident ' s care plan and identifying risk factors as well as interventions designed to reduce or eliminate those considered modifiable. Inspect the skin daily when performing or assisting with personal care or activities of daily living. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) Evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness on an ongoing basis. The facility policy and procedure titled, Protocols for Treatment of Pressure Ulcers Pressure Ulcers/Injuries (undated), documented weekly wound rounds, and wound meetings were to occur to evaluate the progress of treatment and change and update treatment if needed. Nursing evaluated daily and documented/notified medical doctor if any signs of deterioration, infection, significant change were present. Team members for wound rounds included the medical director/wound care specialist, wound care nurse or designee, unit manager, Registered Nurse supervisor or designee, rehabilitation staff, dietician, and consultant surgeon, wound medical doctor (whenever necessary). If a pressure ulcer failed to show some evidence of progress towards healing the pressure ulcer and the resident ' s clinical condition should be reassessed. When residents were identified as at risk for pressure ulcer and/or diagnosed with an actual site, a care plan would be implemented. Care plan would reflect each resident ' s identified needs, efforts implemented to promote prevention and/or healing, and continued evaluation. Residents with pressure ulcers would have their care plans updated. Resident #413 was admitted to the facility with diagnoses of type 2 diabetes (a chronic condition that happens when the body cannot use insulin correctly and sugar levels build up in the blood) dementia, unspecified severity, with other behavioral disturbances (loss of memory) and hypertensive chronic kidney disease (a condition where high blood pressure damages the kidneys, leading to a decline in kidney function). The Minimum Data Set (an assessment tool) dated 9/03/2024, documented the resident had moderate cognitive impairment, could be understood and understand others. The Minimum Data Set Documented Resident #413 was at risk of developing pressure ulcers/injuries, and did not have one or more unhealed pressure ulcers/injuries. (continued on next page)

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	335377	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for Skin Integrity: At Risk for Skin Breakdown, effective 10/24/2024, documented Resident #413 was at risk for skin breakdown. Interventions included: Use pressure reducing cushion when in wheelchair. Review of Treatment Administration Record for November 2024 documented on 11/01/2024 from 3:00 PM to 11:00 PM through 11/03/2024 11:00 PM to 7:00 AM shift to evaluate and document skin check of identified at-risk skin area each shift. All of these dates/shifts documented either intact skin, no issues, or none. On 11/04/2024 on the 3:00 PM to 11:00 PM shift, the Treatment Administration Record documented an opening on Resident #413 ' s coccyx (tail bone) that was cleaned and covered. There was no documented evidence of progress notes or wound assessment on 11/04/2024 that Resident #413 had an opening on the coccyx that was cleaned and covered. Progress note written by Nurse Practitioner #1 dated 11/05/2025 at 1:27 PM documented staff reported an open area to coccyx discovered this morning. No reported injury. Resident #413 was incontinent of bowel and bladder at times, non-ambulatory, used a wheelchair. Progress notes documented decubitus (pressure injury to the skin and underlying tissues that occurred when prolonged pressure was exerted on the body, particularly over bony areas) ulcer of coccyx, Stage 2. No signs of infection. Treatment included trial Santyl once a day with dry dressing, wound care team consult, offload. Physician Order dated 11/07/2024 10:28 AM documented Santyl 250 unit/gram topical ointment. Apply one (1) film by topical route once daily and as needed. Cleanse the sacral area with normal saline. Dry well, apply one (1) application of Santyl, and cover with dry dressing. Nursing Progress Note dated on 11/07/2024 at 10:34 AM written by Registered Nurse #1 documented new orders received for stage 2 pressure ulcer on the sacral area order for Santyl daily and as needed transcribed into electronic medical record. Health care proxy/family member made aware of opening on visit. Treatment Administration Record for November 2024 documented treatment of Santyl 250 ointment, apply one (1) film by topical route once daily and as needed was administered on the 7:00 AM-3:00 PM shift once daily for the dates of 11/07/2024 through 11/18/2024. Wound Care note dated 11/07/2024 documented Resident #413 was being seen by the wound care team. Wound #1 was on the sacral area. It was unstageable. measures 7 centimeters length, 3 centimeters width and depth 0.1 centimeters. no tunneling, wound Bed (nothing documented Small amount of drainage, no odor and peri wound intact. Apply Santyl and dry protective dressing. It documented the resident was improving. Continue with positioning. Case discussed with the wound care team. Will reassess in 1 week. Progress note dated 11/12/2024 documented Resident #413 refused to get out of bed due to pain. They complained of left hip pain and buttock pain where their wound was. The progress note documented to increase tramadol to 50 milligrams every morning, continue Tylenol 1 gram three times a day, and Volteran topical. Left hip x-ray was ordered. Resident #413 had a decubitus ulcer of coccyx, stage 2. Continue Santyl with Dry dressing. Follow up with wound care as scheduled. Physician order dated 11/14/2024 documented a wound consultation with an in-house wound team as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence of weekly wound assessments to monitor the progression of the wound between 11/07/2025 and 11/18/2025. Dietary progress note dated 11/17/2024 documented Resident #413 was being followed on wound rounds for a stage 2 pressure ulcer on their sacrum. Resident #413 was receiving ensure plus three times a day. Progress note dated 11/18/2024 at 2:21 PM written by Assistant Director of Nursing #1 documented they were asked to see Resident #413 due to decline in status. Resident #413 was awake, and minimally responsive Skin was hot and dry. Skin turgor was poor. Tongue furrowed. Resident #413 ' s family member present stated Resident #413 was not like that yesterday when they visited. Nurse Practitioner #1 was called to the unit stat to evaluate the resident. The buttock sacrum wound had declined. Wound and skin record dated 11/18/2024 documented Resident #413 had a pressure ulcer on the sacral area. Risk factors and causes were incontinence and pressure ulcer. Stage: Unstageable slough or eschar. Measures 7 centimeters length by 3 centimeters width and depth 0.1 centimeters, no tunnelling or undermining. Necrotic; black in color. Small amount of serous drainage of less than 25% to dressing . Apply Santyl and dry protective dressing. Resident experiencing pain related to pressure ulcer and unable to communicate. Response to treatment deteriorated. Culture Sent. Physician and family notified. Progress note dated 11/18/2024 at 4:30 PM written by Registered Nurse #1 documented the following: A Certified Nurse Aide approached the Registered Nurse #1 for wound treatment for Resident #413. Upon Registered Nurser #1 entering the room to perform the treatment. Family member of Resident #413 was present and assisted. Resident #413 did not respond during the treatment. Upon assessment, they appeared lethargic and exhibited tremors. The wound on the sacral area showed necrotic tissue and foul odor. Nurse Practitioner #1 and administration were informed of Resident #413 ' s changes in health status. Orders were given to administer Narcan 0.4 milligrams intramuscularly as a one-time dose and Invanz, 1 gram intramuscularly immediately, followed by four additional doses. The Administration and Nurse Practitioner #1 evaluated and discussed the changes in Resident #413 ' s medical condition with the family. Additional orders were received and transcribed according to facility protocol. Nursing progress note on 11/18/2024 documented Resident #413 continued to be unresponsive. Their blood pressure was 154/87. Pulse was 139. Temperature was 102.4. Nurse Practitioner #1 was called and information on their condition was provided. Resident #413 was transported to the hospital. Progress note dated 11/19/2024 at 9:32 AM written by Assistant Director of Nursing #1 documented Resident #413 was admitted to hospital with the diagnosis of sepsis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/05/2025 at 11:50 AM and 5/08/2025 at 9:46 AM, Registered Nurse #1 stated weekly skin checks were done by a nurse on days when a resident took a shower. If there was a concern noted during the skin check, a more formal skin assessment would be completed. Wounds were followed by the wound care team weekly. Registered Nurse #1 stated the wound care team was made up of the Assistant Director of Nursing and someone else from an outside team, but they could not recall. The team would monitor the wounds weekly. They further stated they like to see all wounds and how they are healing. They received a list from Assistant Director of Nursing #1 of residents that have wounds. When asked about Resident #413, Registered Nurse #1 recalled the resident was transferred to the hospital because of a wound on the buttock and a family member reported the resident would not return to the facility due to concerns regarding this pressure ulcer. They stated interventions on Resident #413 ' s skin integrity care plan included to use a pressure reducing cushion on the resident ' s wheelchair. There were no other interventions related to the Pressure Ulcer on it. Registered Nurse #1 state this occurred around the time the facility switched over from using Vendor #2 electronic medical record system to Vendor #1 electronic medical record system and resident ' s care plans needed to be entered manually. Registered Nurse #1 did not know why the skin integrity care plan for Resident #413 was not updated when the Pressure ulcer was discovered. Registered Nurse #1 stated Resident# 413 ' s turning and positioning schedule was not tracked as it was not a task for the Certified Nursing Aides to document when the Resident was turned and positioned. At the time of the switch over to Vendor #1 ' s electronic medical record system, they stated updates made to the care plan were not automatically linked to the care cards followed by the Certified Nursing Aides. They stated they found out a month ago that they needed to update care cards manually when a care plan change was initiated and they have been working every day on having the care plans match the care cards. During an interview on 5/05/2025 at 12:16 PM, Nurse Practitioner #1 stated they could not recall Resident #413. Nurse Practitioner #1 stated wounds were managed by the wound care team and the facility used an outside consulting service for a member on the wound care team. The outside provider participated with facility providers and residents were assessed weekly. Recommendations regarding treatment were made based on the findings of the assessment. Nurse Practitioner #1 stated they reviewed the findings from the wound care rounds and may agree or disagree with recommendations and they would proceed from there. Nurse Practitioner #1 stated skin checks should be done on a weekly basis, but they were not sure which nurse completed the skin checks. They stated based on the results from the skin check, they may make recommendations for the resident to be seen by the wound team. They stated if they were made aware of a skin concern, they would write a progress note about it. If the wound was unstageable, they would implement the appropriate treatment and refer the resident to be seen by the wound care team. During an interview on 5/05/2025 at 12:03 PM, Assistant Director of Nursing #1 stated every resident had an order for a weekly skin check to be done when they have their shower. The skin check was completed by the Certified Nurse Aide and the Licensed Practical Nurse. The Licensed Practical Nurse assessed the skin and identified anything that would need to be addressed by the Registered Nurse. They stated wound assessments were done weekly by themselves and Physician Assistant #1, an outside consultant who was the facility wound specialist. They stated they expected to know of a new concern or wound within 24 hours of an abnormal finding. They stated the first time they saw the wound for Resident #413 was when the resident was sent to the hospital on 11/18/2024. They stated they had Nurse Practitioner #1 see Resident #413 on that day as it was a rough day for the resident and the resident was not doing well. Assistant Director of Nursing #1 stated they were not sure what the treatment for the wound was prior to them seeing the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 5/06/2025 at 11:09 AM, Physician Assistant #1 stated wound rounds were done once a week with themself, Assistant Director of Nursing #1 and the unit manager. They stated they document their findings on a note in the resident ' s electronic medical record. If a Licensed Practical Nurse discovered an area of concern on a skin check, they would expect for them to put the resident down to be evaluated during wound rounds and they would expect a notification so treatment could be initiated for the wound. They could not recall the specifics regarding the pressure ulcer Resident #413 developed and they were not able to access their records during the time of the interview. They stated the most important thing was to identify the wound and start the treatment. Ideally, treatment should have started the day the wound was identified or the next day. Physician Assistant #1 stated there was a delay in treatment for Resident #413 ' pressure ulcer developed on 11/04/2024. Physician Assistant #1 stated Resident #413 should have been reassessed seven (7) or eight (8) days after their first assessment by the wound care team on 11/07/2024 as the recommendation was to reassess this resident in one week. They could not recall if Resident #413 was reassessed during this timeframe. During an interview on 5/06/2025 at 12:15 PM and 5/08/25 at 10:23 AM, Director of Nursing #1 stated the interdisciplinary wound care team that met weekly was comprised of the Assistant Director of Nursing, dietary, therapy, and the nurse manager. The facility had a Physician Assistant that consulted with the facility for wound treatment and the Physician Assistant sent their notes to the facility to be uploaded into the resident ' s chart. If there was a concern noted during a skin check, the Licensed Practical Nurse should notify their supervisor or nurse manager or the provider. If the skin was compromised, an incident and accident report should be initiated. When the Director of Nursing was shown Resident #413 ' s Treatment Administration Record for November 2024 and the entry for 11/04/2024 documenting there was an open area to Resident #413 ' s coccyx, they stated the provider and supervisor should have been notified and an email regarding the open area should have been sent to the Assistant Director of Nursing and an incident and accident report should have been initiated. They noted none of this was done, and a progress note on 11/04/2024 regarding the open area to Resident # 413 ' s coccyx was not written. They stated the staff missed a step. They stated Nurse Practitioner#1 was notified on 11/05/2024 based on the progress note they wrote and the order for the Santyl treatment to the pressure ulcer was initiated on 11/07/2025. Director of Nursing #1 stated the treatment for the pressure ulcer should have been started on 11/05/2024. They stated Resident #413 was not seen weekly for a reassessment of the pressure ulcer as recommended. Director of Nursing #1 stated care plans are a fluid tool and as the resident changes, their care plan should be updated to reflect the change. Comprehensive care plans included every diagnosis and medication a resident had, and it should be personalized as much as possible. Director of Nursing #1 stated the care plan for skin integrity for Resident #413 was not updated when the pressure ulcer was discovered. The only goal on the care plan was for use of the pressure reducing cushion. They would expect to see goals with appropriate interventions such as turning and positioning, offloading, and wound care, but it was not listed on Resident #413 ' s care plan. 10 New York Codes Rules and Regulations 415.12(c)(1)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on observation, record review, and interviews conducted during a recertification and abbreviated survey (Case # ' s NY00371796, NY00358669, NY00357360, NY00363370, NY00371256, NY00353853, NY00347329 and NY00378103), the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, residents stated they were not assisted with care when requested; staff stated they were unable to consistently provide incontinence care, showers, or bed baths due to being short-staffed; and an analysis of the actual staffing schedule showed that on multiple occasions from 3/01/2025 to 4/28/2025, the facility did not ensure minimum staffing levels were met based on the facility assessment. This is evidenced by: Cross reference to F550, F580, F584, F600, F609, F636, F645, F656, F657, F684, F686, F755, F756, F759, F760, F761, F804, F812, F814, F836, F842, F880, F919, F921, F923, F924, F925. Upon entrance to the facility on [DATE], 108 residents resided on two floors. Upon observing and reviewing the Facility Staffing Sheet, six (6) Licensed Nurses and ten (10) Certified Nurse Aides were on duty. During an interview on 4/30/2025 at 12:59 PM, the facility Ombudsman stated that there had been a high facility administration turnover. They stated that a lack of consistent staff associated with the leadership turnover had been an ongoing issue. They stated that residents were not getting the care due to low staffing levels, and showers had been an ongoing issue because of staffing, where the staff would tell the residents they were too short-staffed to provide resident showers. During a surveyor-led group resident meeting on 5/01/2025 at 9:32 AM, five residents who attended the meeting reported insufficient staffing to meet their needs. They stated that they often had to wait an extended period to get care and were yelled at by staff, or staff were rude and disrespectful. They stated that many times they have been left unattended for extremely long times, and the Certified Nurse Aides would say they would come back but never did. During an interview on 5/01/2025 at 9:32 AM, Resident #22 stated when they put their call light on, some Certified Nurse Aides would come into the room and tell them in that they were not their aide, then turn the call light off, leave the room and not come back. They stated it could take one (1) to three (3) hours for someone to finally come in and help them. Resident #22 stated they needed help with using the bathroom and said they had laid in their bed soaking wet after having an accident because Certified Nurse Aides did not respond to the call. Resident #22 stated they felt degraded when Certified Nurse Aides refused to help them. Resident #22 further stated Certified Nurse Aides would argue and fight about their assignments in front of them and other residents, and Certified Nurse Aides and would look directly at them and say that they were not assigned to care for them. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/05/2025 at 1:08 PM, Certified Nursing Aide #1 stated staff were unable to consistently provide incontinence care, showers, or bed baths due to being short-staffed. Certified Nurse Aide #1 stated staff regularly reported the inability to provide care and services to the residents due to staffing issues with administration. During an interview on 5/08/2025 at 10:38 AM, Registered Nurse #1 stated they worked on the care plans but were severely in need of help. Registered Nurse #1 stated that they were told they would receive an assistant last year, but it had not happened. Registered Nurse #1 stated that they worked passing medications, acted as an aide, and spent most of their time working to provide resident care on the unit. The Facility Assessment, last reviewed on 9/10/2024, documented that the facility's bed capacity was 120. The section titled, Staffing Plan, documented the following: - Licensed Nurses providing administrative direction, supervision, and direct care: - Director of Nursing: 1 Registered Nurse full-time Days - Assistant Director of Nursing: 1 Full-Time Employee - Registered Nurse Manager - 2 Full-Time Employees - Registered Nurse Supervisors: Evening and Weekends: 3 Full-time Employees - Licensed Practical Medication Nurses: 5 for days, 5 for evenings, and 3 for nights. - Direct Care Staff: - Certified Nurse Aides: 11 for days, 11 for evenings, 6 for nights. A review of staffing sheets provided by the facility from 3/01/2025 through 4/8/2025 documented that they did not meet their assessed minimum staffing on most shifts for the following: - On 3/02/2025, the nursing schedule had 6 nursing staff during the day shift, 3 for the evening shift, and 2 for the night shift. The Certified Nurse Aide schedule had 8 aides during the day shift, 7 for the evening shift, and 5 for the night shift. - On 3/09/2025, the nursing schedule had 6 nursing staff during the day shift, and 5 for the evening shift. The Certified Nurse Aide schedule had 7 aides during the day shift, 6 for the evening shift, and 2 for the night shift. - On 3/16/2025, the nursing schedule had 6 nursing staff during the day shift, 4 for the evening shift, and 2 for the night shift. The Certified Nurse Aide schedule had 5 aides during the day shift, 6 for the evening shift, and 4 for the night shift. - On 3/25/2025, the nursing schedule had 6 nursing staff during the day shift, 5 for the evening shift, and 3 for the night shift. The Certified Nurse Aide schedule had 7 aides during the day shift, 10 for the evening shift, and 5 for the night shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 4/01/2025, the nursing schedule had 5 for the evening shift and 3 for the night shift. The Certified Nurse Aide schedule had 9 for the evening shift and 3 for the night shift. - On 4/13/2025, the nursing schedule had 6 nursing staff during the day shift, 5 for the evening shift, and 3 for the night shift. The Certified Nurse Aide schedule had 5 aides during the day shift, 5 for the evening shift, and 5 for the night shift. - On 4/20/2025, the nursing schedule had 5 nursing staff during the day shift, 5 for the evening shift, and 3 for the night shift. The Certified Nurse Aide schedule had 7 aides during the day shift, 10 for the evening shift, and 5 for the night shift. - On 4/25/2025, the nursing schedule had 6 nursing staff during the day shift, 5 for the evening shift, and 3 for the night shift. The Certified Nurse Aide schedule had 7 aides during the day shift, 5 for the evening shift, and 4 for the night shift. During an interview on 5/6/2025 at 2:30 PM, Staffing Coordinator #1 stated they determined the staffing levels per the census; it was discussed at the morning meeting what the goal for the staffing levels should be for the next day. They stated that a minimum of three (3) Certified Nurse Aides should be on the first floor and six (6) Certified Nurse Aides should be on the second floor. They stated that if they are short-staffed, they will attempt to fill the spots by offering bonuses or other incentives to get staffing at appropriate levels. During an Interview on 5/06/2025 at 2:55 PM, Assistant Director of Nursing #1, who is also the Nurse educator, described the competency levels for staff. They stated that they perform all competencies during the hiring process and then yearly or when needed if the issue arises. They stated that Certified Nurse Aides had monthly in-services for all areas, including neglect and abuse training. 48413 During an interview on 5/06/2025 at 3:08 PM, Director of Nursing #1 stated that they have tried to meet the regulations every day. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34630 Based on record review and interview during a recertification survey, the facility did not ensure it established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and that it determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Specifically, (a.) the facility did not document receipt of Oxycodone (narcotic pain medication) by the pharmacy for Resident #82, and (b.) did not document nursing unit narcotics as having been counted by two licensed staff members and signed as appropriate on the facility-provided narcotic record sheets for two (2) of two (2) nursing units. This is evidenced by: The Policy and Procedure titled, Medications - Controlled Substances, effective 3/13/2024, documented it was the facility ' s policy to comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). Handling Controlled Substances documented controlled substances were counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals signed the designated controlled substance record. If the count was correct, an individual resident-controlled substance record was made for each resident who would be receiving a controlled substance. The record included the quantity received, date and time received, and signature of person receiving medication. Dispensing and Reconciling Controlled Substances documented, controlled substance inventory was monitored and reconciled to identify loss or potential diversion in a manner that minimized the time between loss/diversion and detection/follow-up. Nursing staff count controlled medication in inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing Services. Resident #82: Resident #82 was admitted to the facility with diagnoses of hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke) affecting one side of the body, unspecified pain, and anxiety disorder. The Minimum Data Set (an assessment tool) dated 4/28/2025, documented the resident was cognitively intact, was able to make themselves understood, and understood others. Physician Order dated 4/29/2025, documented Oxycodone 10 milligram tablet, give one (1) tablet (10 milligrams) by oral route every four (4) hours as needed for unspecified pain. Maximum daily dose: six (6) tablets. Individual Patient Controlled Substance Administration Record dated 4/29/2025, documented Oxycodone 10 milligram tablet, one (1) tablet every four (4) hours as needed. Maximum daily dose: six (6) tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record did not document the signature of the person and title receiving the drug, the date received, and the amount received. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, Team #s 1 and 2, dated April 2025, did not consistently document signatures by the off-going and oncoming nurse. For instance, 4/13/2025, 4/26/2025, and 4/30/2025 7AM - 3PM did not document a signature for the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, Team #s 1 and 2, dated May 2025, did not consistently document signatures by the off-going and oncoming nurse. For instance, 5/1/2025 and 5/5/2025 7AM - 3PM did not document a signature for the off-going nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the second-floor nursing unit, Team East; West; and North, dated April 2025, did not consistently document signatures by the off-going and oncoming nurse. For instance, North team on 4/7/2025 11PM - 7AM did not document a signature for the off-going and oncoming nurse. 4/8/2025 3PM - 11PM did not document a signature for the off-going and oncoming nurse. 4/16/2025 7AM - 3PM, 3PM - 11PM, and 11PM - 7AM did not document a signature for the off-going and oncoming nurse. [NAME] team on 4/2/2025 3PM - 11PM, did not document a signature for the off-going nurse and 11PM - 7AM did not document a signature for the oncoming nurse. 4/6/2025 7AM - 3PM and 3PM - 11PM did not document a signature for the off-going nurse. East team on 4/1/2025 3PM - 11PM did not document a signature for the oncoming nurse and the 11PM to 7AM did not document a signature for the off-going nurse. 4/25/2025 7AM - 3PM did not document a signature for the off-going and oncoming nurse and 3PM - 11PM did not document a signature for the off-going nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the second-floor nursing unit, Team West, dated May 2025, did not consistently document signatures by the off-going and oncoming nurse. For instance, on 5/1/2025 7AM - 3PM did not document a signature for the off-going nurse. 5/06/2025 7AM - 3PM did not document a signature for off-going nurse and 11PM - 7AM did not document a signature for the oncoming nurse. During an interview on 5/07/2025 at 11:05 AM, Licensed Practical Nurse #3 stated they always counted the narcotics but did not always sign the paper that the count was done. During an interview on 5/07/2025 at 3:13 PM, Licensed Practical Nurse #2 stated they learned about the narcotic issue that day (5/07/2025) and completed an actual count with the nurse. They stated they just reviewed the process of narcotic counting with staff. They stated ultimately, the licensed nurse was responsible for counting the narcotics, because they were licensed professionals and were accountable for everything they did. During an interview on 5/08/2025 10:39 AM, Licensed Practical Nurse #2 stated the supervisor was responsible for receiving narcotics from the pharmacy and was to count them, sign for them, and document the date medication was received. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025 at 12:55 PM, Director of Nursing #1 stated they would expect the narcotics to be counted and narcotic count sheets to be signed by the off-going and oncoming nurse. They further stated the controlled substance records should have been signed by two (2) nurses when the narcotics were received from the pharmacy. They stated they expected narcotics would be counted at time of receipt. 10 New York Code Rules and Regulations 415.18(a)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 33538 Based on record review and interview conducted during the recertification survey, the facility did not ensure development of policies and procedures for the monthly drug regimen review that included, but was not limited to, timeframes for the different steps in the process. Additionally, the drug regimen of each resident was not reviewed at least once a month by a licensed pharmacist. Specifically, the facility policy titled, Medication Regimen Review, did not identify time frames for steps in the medication review process. Additionally, there was no documented evidence of a pharmacist's review of the medication regimens for January, February, and March of 2025, affecting all residents. This is evidenced by: 43805 The facility policy titled, Medication Regimen Review, created 7/19/2019 with no updates or revisions, documented the Consultant Pharmacist should review the medication regimen of each resident at least monthly. The Consultant Pharmacist will document his/her findings and recommendations on the monthly drug/medication regimen review report. If the situation was serious enough to represent a risk to a person ' s life, health, or safety, the Consultant Pharmacist would contact the Physician directly to report the information to the Physician and would document such contacts. The Consultant Pharmacist would provide the Director of Nursing Services and Medical Director with a written, signed and dated copy of the report, listing the irregularities found and recommendations for their solutions. 48413 The facility policy did not address the time frames for steps in the Medication Regimen Review process. During an interview on 5/05/2025 at 2:59 PM the Director of Nursing confirmed that as far as they know, the pharmacy did not provide medication regimen reviews for January, February, and March 2025. They were not the Director of Nursing at this facility for those months. They stated that they were not aware the policy did not have the required time frames. 10 New York Code Rules and Regulations 415.18(c)(2)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure medication error rates are not 5 percent or greater. 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5 percent for one (1) (Resident # 6) of four (4) residents observed during medication administration with 25 observations. This resulted in a medication error rate of 36 percent. This is evidenced by: The facility ' s Policy and Procedure titled, Administering medications, effective 3/13/2024, documented medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Resident #6 Resident #6 was admitted to the facility with the diagnoses of congestive heart failure (when the heart can't pump blood well enough to give the body a normal supply), chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs resulting in swelling and irritation), and depression (a constant feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool) dated 3/06//2025 documented the resident was able to be understood and was able to understand others with intact cognition. The Medication Administration Record dated April 2025 for Resident #6 documented the following medications were to be administered at 9:00 AM: Albuterol sulfate 2.5 milligram/3 milliliter (0.083 percent) solution for nebulization. Inhale 3 milliliters (2.5 milligram) by nebulization route every 6 hours as needed Cardizem CD 240 milligram capsule, extended release. Give 1 capsule (240 milligram) by oral route once daily. Eliquis 5 milligram. Give 1 tablet (5 milligram) by oral route 2 times per day. Lasix 40 milligram. Give 1 tablet (40 milligram) by oral route once daily Magnesium oxide 400 milligram (241.3 milligram magnesium). Give 1 tablet by oral route once daily Olanzapine 2.5 milligram. Give 1 tablet (2.5 milligram) by oral route once daily. Trelegy Ellipta 200 microgram-62.5 microgram-25 microgram powder for inhalation. Inhale 1 puff by inhalation route once daily. Venlafaxine ER 150 milligram capsule. Give 1 capsule (150 milligram) by oral route once daily. Enteric Coated Aspirin 81 milligram. Give 1 tablet (81 milligram) by oral route once daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the medication administration observation on 04/30/2025 at 10:40 AM, Licensed Practical Nurse #7 administered the above medications to resident #6 at approximately 10:45 AM. Licensed Practical Nurse #7 stated they were always this late with their morning medication pass because they had 28 residents with a lot of medications. They were unable to administer them on time. They further stated Human Resources spoke with them regarding the late medications, and they explained the medications pass was too heavy for one person. They also stated the nurse manager was aware, and they were not given any assistance. During an interview on 04/30/2025 at 10:47 AM, Registered Nurse #1 stated Human Resources spoke with Licensed Practical Nurse #7. Registered Nurse #1 stated no assistance was provided because other nurses were completing the same medication pass on time. They stated they plan to do an audit on Licensed Practical Nurse #7 sometime in the future. Registered Nurse #1 stated the nurse performing the medication pass was responsible for notifying the nurse practitioner when medications are late. During an interview on 04/30/2025 at 10:55 AM, Nurse Practitioner #1 stated nursing staff should have notified them when medications are late either by phone or in person when they are in the building. They had not been notified of any late medications on this day. They further stated that on the previous day (4/29/2025), there was an entry made by Licenses Practical Nurse #7, in the Nurse Practitioner communication book that medications were late. During an interview on 05/08/2025 at 11:49 AM, Director of Nursing #1 stated there had been problems with Licensed Practical Nurse #7 administering medications on time. The expectation for all nurses was to adhere to the policy of administering medications one hour before or after ordered time. When a nurse finds themselves late in giving medications, they should immediately notify the physician and or nurse practitioner of the late medication(s) via telephone or in person, then notify their supervisor or manager, who can provide help. At no time should notification of any late medication be placed in the Nurse Practitioner/Physician communication book. All Registered Nurses and Licensed Practical Nurses received training on medication administration upon hire and with annual competencies. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on observations, record review, and interviews conducted during a recertification and abbreviated survey (Case #'s NY00344251, NY00348580, NY355929, NY00347329 and NY00371796), the facility failed to ensure residents were free of significant medication errors for six (6) (Resident #s 10, 70, 82, 86, 107 and 416) of six (6) residents reviewed for medication administration. Specifically, (a.) Residents #s 10 and 70 had orders for antibiotic eye ointment that were not administered as ordered. (b.) Resident #82 had an order for narcotic pain medication that was not administered as ordered. (c.) Residents #s 86 and 107 had orders for antibiotics that were not administered as ordered. (d) Resident #416 was given medication that was not ordered for them. This is evidenced by: The facility policy titled, Medication Administration, created 4/2013 and last revised 12/2019, documented medications shall be administered in a safe and timely manner, and as prescribed. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document as such in designated format (hard copy or electronic) space provided for that drug and dose. There was no documented evidence that the policy addressed notification of the medical provider when medications were not administered as ordered. Resident #10 Resident #10 was admitted to the facility with a diagnosis of type (two) 2 diabetes, chronic obstructive pulmonary disease (narrowing of airways) and chronic atrial fibrillation (an irregular heart rate). The Minimum Data Set (an assessment tool) dated 2/06/2025 documented the resident could be understood, could understand others, and was cognitively intact. A Physician ' s Order dated 1/25/2025, documented the resident was to receive Tobradex ophthalmic 0.1/0.3 percent eye ointment to the right eye, (two) 2 drops to the right eye (four) 4 times per day for (seven) 7 days for conjunctivitis. Review of the Medication Administration Record for January 2025 documented TobraDex eye ointment was to be administered at 9 AM, 1 PM, 5 PM, and 9 PM. This medication was not administered on the following dates and times: 1/26/2025 at 9 AM and 1 PM. Reason was due to clinical monitoring. 1/26/2025 at 5 PM. Reason was due to within normal range. 1/26/2025 at 9 PM. Reason was due to clinical monitoring. 1/27/2025 at 9 AM, 1 PM, 5 PM and 9 PM. Reason was due to clinical monitoring. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/28/2025 at 5 PM and 9 PM. Reason was below normal parameters. 1/30/2025 at 9 AM and 9 PM due to clinical monitoring. Nursing progress note dated 2/01/2025 documented Resident #10 completed TobraDex. There was no documentation in Resident #10 ' s electronic medical record progress note section that indicated Resident #10 was not administered TobraDex eye ointment on the above dates/times. During an interview on 5/08/2025 at 9:46 AM, Registered Nurse #1 stated if medications were not administered, the Licensed Practical Nurse should have notified the Nurse Practitioner on call. Registered Nurse #1 looked at the Medication Administration record for Resident #10 for the month of January 2025 and stated TobraDex eye ointment was not administered each day as ordered. During an interview on 5/08/2025 at 12:30 PM, Nurse Practitioner #1 stated they had been notified in the past when residents did not receive their medications. They assumed nursing staff would notify them if there was a missed dose of a medication because they may have been able to offer an alternative depending on the circumstance (such as if a medication was not available, they could offer an alternative medication in the meantime). Nurse Practitioner #1 stated that they could not recall receiving notifications that Resident #10 did not receive the TobraDex eye ointment as ordered. During an interview on 5/08/2025 at 10:23 AM, Director of Nursing #1 stated when a provider ordered a medication or treatment for a resident, it was documented on the medication administration record and/or treatment administration record. Director of Nursing #1 was shown the Medication Administration Record for January 2025 for Resident #10. They stated TobraDex was initiated for this resident in January 2025, but there were missed doses of the medication. They stated that they were not aware why clinical monitoring would be documented for a reason as to why administration of TobraDex did not occur. They stated there were no progress notes that documented why the medication was not administered to Resident #10. Resident #107 Resident #107 was admitted to the facility with the diagnoses of type (two) 2 diabetes, atrial fibrillation (an irregular heart rate), and cellulitis (bacterial infection of the skin). The Minimum Data Set, dated dated dated [DATE] documented the resident could be understood, could understand others, and was severely cognitively impaired. The Physician's Order dated 4/22/2025 documented Rocephin (one) 1 gram solution for injection, give (one) 1 gram intramuscular route once daily for (five) 5 days. The Medication Administration Record for April 2025 documented (four) 4 doses were given over (four) 4 days. The antibiotic was not administered on 4/24/2025, the reason documented was, there was no lidocaine (a pain-relieving medication that can be mixed with other medications to help prevent pain at an injection site). A review of the progress notes for 4/22/2025-4/30/2025 had no documentation a physician being informed and dosages changed due to receiving less than the prescribed dosages. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/08/2025 at 10:16 AM, Assistant Director of Nursing #1 stated that the medical provider should be informed of any missed doses of an antibiotic so the schedule can be extended or adjusted to ensure the resident received each ordered dose. They stated conversations with the medical provider should always be documented in the progress notes. During an interview on 5/08/2025 at 1:11 PM, Licensed Practical Nurse #2 stated the doctor should have been called for any missing dose. They stated that lidocaine is always available, and they were never made aware of any shortage. They stated the nurse that did not administer the ordered dose was no longer employed at the facility. 34630 Resident #416 Resident #416 was admitted to the facility with the diagnoses of right hemiplegia (paralysis of one side of the body) following a cerebral infarction (disrupted blood flow to the brain); Parkinson ' s Disease (a movement disorder of the nervous system that worsens over time), and Muscle Weakness (when muscles aren't as strong as they should be). The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood and could understand others with severe cognitive impairment. The hospital progress note dated 6/07/2024 documented, Per medical records, resident unintentionally received 40 units of Lantus Sunday prior to admission. Resident was brought to Hospital on 6/03/2024 and was admitted . Nursing progress note dated 6/03/2024 at 6:43 AM documented, reported by roommate that resident was given their PM dose of insulin. Resident ' s blood glucose this morning was 88. Resident was noted to be more sluggish than usual this morning and was given ensure to bring blood sugar up. Supervisor notified and, repeat check of blood sugar was 108. Resident #416 ' s Medication Administration Record dated June 2024, did not include an order for Lantus or any other insulin medication. The Medication Error Report dated 6/03/3024, documented Resident #416 received Lantus 40 units without a physician order. During an interview on 5/08/2025 at 11:49 AM, Director of Nursing #1 stated Licensed Practical Nurses and Registered Nurses receive medication administration training upon hire as well as completed annual competencies. Nurses follow the six (6) rights for medication administration that include verifying (1) right patient (2) right drug (3) right dose (4) right time (5) right route (6) right documentation. 10 New York Codes Rules and Regulations 415.12(m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Regulation S483.45(h)(2): The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for one (1) of two (2) Medication Rooms (2nd floor); and for two (2) of three (3) medication carts (first floor unit 100 and second floor unit 300) reviewed. Specifically, (a.) two (2) open bottles of lidocaine injectable solution had no open and or expiration dates (b.) seven (7) insulin kwik pens had no expiration dates (c.) one (1) inhaler had no open and or expiration date, and four (4) other inhalers had no expiration dates. Additionally, (d.) for the second-floor medication room narcotic box 1 West, both inside and outside locks were broken. The first-floor medication room narcotic boxes had no keys and were inaccessible to staff. Narcotics were observed to be stored on medication carts. This is evidenced by: The facility ' s Policy and Procedure titled, Administering medications, with effective date of [DATE] documented the following: 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. 13. Vials labeled as single dose or single use are not used on multiple residents. Such vials are used only for one resident in a single procedure. 15. Insulin pens are clearly labeled with the resident ' s name or other identifying information. 16. All multidose injectable medications will be labeled with the date opened and expiration date. 30. Each nurses ' station has a current medication reference, as well as a copy of the surveyor guidance for F,d+[DATE] (Pharmacy Services) available. Manufacturer ' s instructions or user ' s manuals related to any medication administration devices are kept with the devices or at the nurses ' station. During an observation on [DATE] at 10:59 AM, the second floor medication cart [NAME] Unit 300 contained two (2) opened lidocaine bottles with no open and or expiration date; four (4) opened insulin pens (1 Humalog, 2 Lantus and 1 Lispro) with no expiration dates; and three (3) opened inhalers (fluticasone; budesonide and incruse ellipta) with no expiration dates. During an observation on [DATE] at 11:15 AM, the second-floor medication room contained a narcotic box. The inside lock had been removed leaving an open hole where lock should had been. The outside lock could not be fully secured and was partially opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 11:20 AM, Licensed Practical Nurse #5 stated the narcotic box lock had been broken for several weeks and that their maintenance department had previously tried to repair locks. Registered Nurse #1 stated maintenance was aware locks still were in need of repair and it was on their to do list. During an observation on [DATE] at 11:40 AM, the first floor medication cart East Unit 100 contained one (1) albuterol inhaler with no name, no open or expiration date; one (1) incruse ellipta inhaler with no expiration date; three (3) opened insulin pens (2 Lantus and 1Toujeo) with no expiration dates. During an interview on [DATE] at 11:45 AM, Registered Nurse #2 stated they were not aware of medications with shortened expiration dates and were unable to verbalize when insulins and or inhalers expired after opening. Registered Nurse #2 stated they did not utilize the narcotic lock box in the medication room and that narcotics were instead kept on the medication cart. During an interview on [DATE] at 11:48 AM, Assistant Director of Nursing #1 stated the first floor did not use the narcotic box in the mediation room due to a disagreement that occurred when the medication room was moved to a different location several months ago. They further stated that since that time, narcotics had been stored in the medication cart. During an interview on [DATE] at 11:49 AM, Director of Nursing #1 stated the medication nurse was responsible to ensure their cart was clean and orderly. They stated that upon opening, medications should have been labeled with open and expiration dates; their pharmacy vendor should also have conducted medication cart audits. Director of Nursing #1 stated narcotic box locks on the second floor were immediately repaired on [DATE], and new keys were made for the narcotic box on the first floor and was now in use. 10 New York Codes, Rules, and Regulations 415.18(d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33538 Based on observations and interviews during a recertification survey the facility did not ensure food and drink were palatable and attractive for two of two units test trays and one (1) (Resident #61) of one (1) resident reviewed for palatable and appealing food and drink. Specifically, (a) resident #61 complained that the food was usually inedible, often unidentifiable, and not what was on the meal ticket. (b) Test trays on two (2) of two (2) units were identified by surveyors as unpalatable. This is evidenced by: The Minimum Data Set, dated dated dated [DATE], documented the Resident #61 was cognitively intact, was able to make themselves understood and understood others. During an interview on 4/30/2025 at 12:28 PM, Resident #61 stated the quality of the food was not good. They stated they were served a mystery meat patty covered with gravy and vegetables are overcooked. Alternate was a sandwich on stale bread. Resident #61 further stated sometimes they were supposed to have coleslaw but receive macaroni salad instead. They further stated that they had not received fresh fruit in a long time, and do not get a choice, ' you eat what they give you. ' During an observation on 4/30/2025 at 12:28 PM, Resident #61 ' s meal ticket dated 4/30/2025 documented oven fried chicken, braised red cabbage, cream of corn, canned fruit. The meal tray contained chicken covered with gravy, green beans, an unidentifiable reddish-brown substance, cream of corn, and fruit. All of which was uneaten. 34630 During a test tray on 5/08/2025 at 11:59 AM on Unit 1, the meal ticket documented roast pork, baked sweet potatoes, and cauliflower. The roast pork was covered with salty gravy. The baked sweet potato appeared to be boiled, was mushy and waterlogged. The cauliflower was overcooked and easily mashed when pressed down with a fork. None of the food items were palatable. During a test tray on 5/08/2025 at 12:13 PM on Unit 2, the food served was overcooked and determined to be of poor quality. The roast pork was overcooked and dry with salty gravy. The baked sweet potato appeared to have been boiled with skin on and had no flavor. The cauliflower was overcooked and mushy. None of the food items were palatable. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)

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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. 21414 Based on observation, record review, and interview conducted during the recertification survey, the facility did not store, prepare, distribute or serve food in accordance with professional standards for food service safety in the main kitchen and two (2) (First Floor Unit and Second Floor Unit) of two (2) kitchenettes. Specifically, the dishwashing machine final rinse water pressure was too low, equipment was not in good repair, and surfaces were not clean. This is evidenced by: During observations of the main kitchen and unit kitchenettes on 4/29/2025 from 6:26 PM through 7:45 PM: The water pressure during the final rinse of the automatic dishwashing machine was zero pounds per square inch; the dishwashing machine data plate stated that the water pressure was to be between 15 and 25 pounds per square inch. The steamtable sink faucet leaked, the cold-water faucet did not work, and the faucet fixture was loose. The handwashing sink paper towel dispenser was empty. The metal finish was torn off on two 6-inch sections on the exterior bottom of the walk-in freezer and one 6-inch section of the walk-in refrigerator. 12 ceramic wall tiles were missing. Seven floor tiles adjacent to the exit doors in the dietary suite corridor were broken and cracked. Water was puddled on the floor of dishwashing machine room. In the Second Floor Unit kitchenette, the bottom interior of the sink cabinet was heavily warped, cracked, and had multiple exposed sections of exposed unsealed particleboard. During observations of the main kitchen and unit kitchenettes on 4/29/2025 from 6:26 PM through 7:45 PM, the following areas soiled with food particles and/or dirt: Spice rack tray. Handwashing sink. Fire extinguishers. Ceiling and ceiling lights. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Kitchen windows. Floor in corners and next to walls. Kitchen office floor. Emergency food stock room floor. Dietary suite corridor floor. Janitor closet floor. First Floor Unit kitchenette floor. Second Floor Unit kitchenette floor. During an interview on 4/29/2025 at 7:22 PM, Food Service Director #1 stated that the pressure gauge, missing wall tiles, puddling water, loose faucet, exterior of the walk-in freezer and refrigerator, broken floor tiles, and kitchenette sink will be reported for repair to the maintenance department. The paper towel dispenser would be refilled, and the cleaning items would be immediately addressed. They further stated that the kitchenette floors would be reported for cleaning to the housekeeping department. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 21414 Based on observation and interviews conducted during the recertification survey, the facility did not ensure garbage and refuse was disposed properly. Specifically, the garbage dumpster was not closed, and garbage littered the area. This is evidenced by: During observations on 4/29/2025 at 7:03 PM, the side door of the garbage dumpster was not closed, and garbage littered the area around the dumpster and side of the parking lot. During an interview on 4/29/2025 at 7:30 PM, Food Service Director #1 stated that they would re-educate staff to keep the dumpster doors closed and would speak with the maintenance and housekeeping departments regarding picking up the litter. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 21414 Based on observation and interview conducted during the recertification survey, carbon monoxide detection was not provided in accordance with adopted regulation. Specifically, carbon monoxide detection was not installed in main kitchen by gas fuel fired equipment (e.g., stove). This is evidenced by: During observations in the main kitchen on 4/29/2025 at 6:26 PM, a carbon monoxide detector was found on the shelf below the steamtable and not installed as required in the stove area. During an interview on 5/07/2025 at 3:14 PM, Director of Maintenance #1 stated that they would consult with corporate maintenance and reinstall the carbon monoxide detector. 10 New York Codes, Rules, and Regulations 400.2 2015 International Fire Code, Section 915

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51317 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure resident medical records contained an accurate representation of the actual experiences of the resident and included enough information to provide a picture of the resident ' s progress, including their response to treatments and services, and changes on their condition, plan of care, objectives, and/or interventions. Specifically, (a.) for Resident #61, the facility did not ensure Daily Medicare Notes accurately documented the resident ' s wounds and, (b.) for Resident #s 70 and 86, the facility did not ensure documentation of the residents ' condition that required antibiotic treatment. This is evidenced by: Resident #61: Resident #61 was admitted to the facility with diagnoses of displaced fracture of greater trochanter of right femur (fracture of upper part of thigh bone), multiple myeloma (cancer that forms in a type of white blood cell), and unspecified heart failure (a condition where the heart is not pumping effectively) . The Minimum Data Set (an assessment tool) dated 5/01/2025, documented the resident was cognitively intact, was able to make themselves understood and understood others. Wound Care Note dated 2/27/2025 by Physician Assistant #1 documented the resident had wounds on the right lower extremity, left lower extremity, left medial calf, bilateral feet, and bilateral buttocks. Treatments were documents for all wounds. Daily Medicare Note dated 2/27/2025 and 2/28/2025 by Registered Nurse #2 documented the resident had no wounds. Resident #70: Resident #70 was admitted to the facility with diagnosis including dementia (a group of thinking and social symptoms that interferes with daily functioning)major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that interfere with daily life), and acute atopic conjunctivitis. (a chronic, allergic eye condition primarily affecting adults with a history of atopic dermatitis characterized by inflammation of the clear membrane covering the whites of the eyes and inner surfaces of the eyelid), The Minimum Data Set, dated dated dated [DATE] documented the resident could rarely be understood, could rarely understand others, and was severely cognitively impaired. Medical Provider Note dated 4/08/2025 documented a staff report of increased redness to right eye. Conjunctivitis, trial ofloxacin ophthalmic 0.3 percent, two (2) drops both eyes four (4) times daily for seven (7) days. Review of Nursing Progress Notes revealed no documentation of the resident ' s condition related to the need for antibiotic treatment prior to, during, or after the treatment was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident# 86: Resident #86 was admitted to the facility with diagnosis including chronic obstructive pulmonary disease (lung and airway diseases that restricts breathing), polyneuropathy (damage affecting nerves), and pleural effusion (accumulation of fluid surrounding the lungs). The Minimum Data Set, dated dated dated [DATE], documented the resident could be understood, could understand others, and was cognitively intact. A Medical Provider Note dated 4/29/2025 documented the resident was seen for staff reports of chest congestion. Chest x-ray, DuoNeb, and Mucinex ordered. A trial of Invanz (a broad spectrum antibiotic effective against a wide range of bacteria) 1 gram was to be given one time.T A Medical Provider Note dated 5/01/2025 documented the resident was seen for continued cough. Chest x-ray reveals mild left basilar infiltrate with small left pleural effusio(a buildup of fluid between the tissues that lined the lungs and the chest) and mild right infrahilar infiltrate (a collection of abnormal substances like pus, blood, or protein in the lung tissue below where the lungs connected to the airway and blood vessels). Start Levaquin 500 milligrams daily for seven (7) days. Review of Nursing Progress Notes revealed no documentation of the resident ' s condition related to the need for antibiotic treatment prior to, during, or after the treatment was completed. Interviews: During an interview on 5/07/2025 at 3:13 PM, Licensed Practical Nurse #2 stated Resident #61 was originally treated for edema and vascular issues. They stated the edema in their legs turned into blisters and open wounds. They stated the Resident #61 was being seen on wound round by Physician Assistant #1. They stated that according to Physician Assistant ' s written notes on 2/27/2025, Resident #61 had wounds on their left and right inner calf, toes, and buttocks. During an interview on 5/08/2025 at 11:17 AM, Licensed Practical Nurse #2 stated they did not understand why Registered Nurse #2 was documenting in the Daily Medicare Notes that Resident #61had no wounds. They stated the Resident #61 had wounds and Registered Nurse #2 was providing wound care to the resident daily. During an interview on 5/08/2025 at 2:54 PM, Licensed Practical Nurse #8 stated if a resident was on antibiotics, there should have been notes about their condition and progress. During an interview on 5/08/2025 at 1:05 PM Licensed Practical Nurse #2 stated there should have been progress notes describing the resident's condition and progress during antibiotic treatment. 10 New York Codes Rules and Regulations 415.22(a)(1-4)

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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** 43805 Based on observations, record reviews, and interviews conducted during a recertification survey, the facility did not ensure an infection control program was implemented to prevent the transmission of communicable diseases to residents. Specifically, (a.) for Resident #64, enhanced barrier precautions were not implemented for the resident who had an indwelling catheter; (b.) for Resident #97, the resident's nebulizer equipment was not stored to prevent contamination of the equipment. This is evidenced by: Resident #64 Resident #64 was admitted to the facility with the diagnoses of polyneuropathy (peripheral nervous system disorders that impact nerve function), chronic obstructive pulmonary disease (lung disease characterized by chronic respiratory symptoms and airflow limitation), and type 2 diabetes mellitus. The Minimum Data Set (an assessment tool) dated 2/24/2025 documented the resident understood, could understand others, had moderately impaired cognition, and had an indwelling urinary catheter. The policy and procedure titled, Enhanced Barrier Precautions and last reviewed 2/19/2025, documented enhanced barrier precautions were indicated for residents with wounds and/or indwelling medical devices even if the resident was not known to be infected or colonized with a multi drug resistant organism. During multiple observations on 4/29/2025, 4/30/2025, 5/02/2025, and 5/05/2025, there was no signage for enhanced barrier precautions and no personal protective equipment cart near the resident's room. A Physician's Order dated 11/04/2024 documented enhanced barrier precautions for Resident #64 related to indwelling catheter and wounds. During an interview on 5/06/2025 at 10:46 AM, Registered Nurse #1 could not say why Resident #64 was not on enhanced barrier precautions. They stated they were aware that the resident had an indwelling urinary catheter. Resident #97 Resident #97 was admitted to the facility with the diagnoses of chronic respiratory failure (when lungs cannot properly exchange gases), chronic obstructive pulmonary disease, and congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs). The Minimum Data Set, dated dated dated [DATE] documented the resident was understood, could understand others, and was cognitively intact. The policy and procedure titled, Administration of Nebulizer Medication last reviewed 8/2024 documented once treatment is complete to rinse, dry, and store nebulizer per facility policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During multiple observations on 4/29/2025, 4/30/2025, 5/02/2025, 5/05/2025, and 5/06/2025, the nebulizer equipment was on the resident's bedside table with the nebulizer mask laying uncovered on the nebulizer machine. A review of current Physician Orders did not document an order for rinsing/cleaning the nebulizer equipment after use. During an interview on 5/06/2025 at 10:43 AM, Licensed Practical Nurse #1 stated the nebulizer mask or pipe should be rinsed, dried, and stored in a plastic bag after each use. During an interview on 5/06/2025 at 10:46 AM, Registered Nurse #1 stated the nebulizer mask should be stored in a bag if one is available, otherwise the mask can be placed on a paper towel. In an e-mail received 5/07/2025 at 2:02 PM, Director of Nursing #1 clarified that the facility policy for storing nebulizer equipment was to store in a bag at the bedside. During an interview on 5/08/2025 at 10:16 AM, Assistant Director of Nursing #1 stated that nebulizers should be rinsed, dried, and stored in a plastic bag. They stated that laying a nebulizer on a paper towel or on top of the nebulizer machine would not be correct. During an interview on 5/8/2025 at 10:16 AM, Assistant Director of Nursing #1 stated that any nurse could contact the medical provider for the order to initiate transmission-based precautions including enhanced barrier precautions. They stated that unit managers should be rounding their units daily to ensure transmission-based precautions were in place as ordered. New York Codes, Rules, and Regulations 415.19(a)(1-3)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414 Based on observation, record review, and interviews conducted during the recertification and abbreviated survey (Case #NY00354621), the facility did not adequately provide for residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area on two (2) of two (2) units. Specifically, the facility nurse call system did not function in resident room #s 203 and 320. This is evidenced by: During observations on 4/29/2025 at 8:03 PM, the call bell device in the resident room [ROOM NUMBER] bathroom was missing from the mounting hardware and the wires were hanging out of the mounting hardware. During an observation on 05/06/2025 at 1:02 PM, the call bell device was hanging by wires and not mounted to wall in resident room [ROOM NUMBER]. Workorders dated 10/29/2024 through 4/15/2025 documented 10 instances of call bell disrepair. There was no documented evidence that workorders were submitted to repair the call bells in room #s 203 and 320. During an interview on 5/07/2025 at 3:05 PM, Director of Maintenance #1 stated that they would repair the call bells in room #s 203 and 320. 10 New York Codes, Rules and Regulations 713-1.3(b)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 21414 Based on observation and interviews conducted during the recertification survey, the facility did not provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the exterior of the facility building, and grounds were not clean and maintained. This is evidenced by: During observations on 5/05/2025 from 12:04 PM through 12:31 PM: Sections of the lower portion of the building facade was covered with moss and algae. Piles of old construction materials and accumulations of leaves and litter were found on the grounds along the building. The garbage dumpsters were not seated in the designated fenced area; vegetation was encroaching on the fencing. During an interview on 5/07/2025 at 3:09 PM, Director of Maintenance #1 stated that they would have the construction debris and litter picked up, the vegetation cut back and direct the vendor to place the dumpster in the designated area. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. 21414 Based on observation and interviews conducted during the recertification, the facility did not ensure adequate ventilation of one (1) (second floor) of (2) resident units. Specifically, the Second Floor Unit Soiled Holding Room and shower room were not adequately ventilated. This is evidenced by: During observations on 4/29/2025 at 8:47 PM, unpleasant odors were found in the Second Floor Unit Soiled Holding Room and a heavy must odor was found in the Second Floor Unit shower room. During an interview on 5/07/2025 at 3:10 PM, Director of Maintenance #1 stated that the motors servicing the ventilation system for the Second Floor Unit Soiled Holding Room and the Second Floor Unit shower room were not powerful enough to remove the odors and required replacement. 10 New York Codes, Rules and Regulations 483.90(i)(2)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 21414 Based on observation and interviews conducted during a Recertification Survey, handrails were not maintained on two (2) of two (2) resident units. Specifically, handrails had broken plastic and missing pieces exposing sharp edges. This is evidenced by: During observations on 04/29/2025 at 7:51 PM through 8:58 PM: The Second Floor Unit south corridor handrail had a six (6)-inch section of broken plastic with sharp edges. The Second Floor Unit Elevator one (1) corner guard had broken plastic with sharp edges. The First Floor Unit handrail had six (6) areas where the edge turn pieces missing exposing sharp edges. During an interview on 5/07/2025 at 3:03 PM, Director of Maintenance #1 stated that they would repair the broken plastic and install the missing pieces on the handrails. 10 New York Codes, Rules, and Regulations 713-1.8(a)

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Troy Victorian Rehabilitation & Nursing Care Cntr	100 New Turnpike Road Troy, NY 12182

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 - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414 Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (Case #s NY00354621, NY00355929, NY00356190, and NY00357360), the facility did not maintain a pest-free environment and an effective pest control program on two (2) of two (2) resident units. Specifically, insect infestation was found in resident rooms, the main kitchen, and staff areas. This is evidenced by: During observations on 4/29/2025 at 8:45 PM, a resident was heard yelling, ' There is a bee in my room, ' and a wasp was found flying in resident room [ROOM NUMBER]. Director of Maintenance #1 immediately found and killed the wasp. During observations on 5/05/2025 at 1:55 PM, gnat-like flies were found in the conference room. During observations on 5/06/2025 from 10:17 AM through 1:49 PM, gnat-like flies or ants were found in resident room [ROOM NUMBER] and the employee break room. During observations on 5/07/2025 at 11:12 AM, gnat-like flies were found in the main kitchen dishwashing area. The document titled [vendor] Pest Management, the facility pest-sighting logbook, documented that fruit flies were found in room #s 207 and 226 during 9/2024. The document titled [vendor] Pest Management documented that the facility was treated for ants during 4/2025 and for small flies in the dishwasher area of the kitchen periodically from 5/2024. There was no documented evidence that the facility was treated for wasps. There was no documented evidence that the facility was treated for small flies and ants in resident room [ROOM NUMBER] or for small flies the conference room or the employee break room since 5/2024. During an interview on 5/07/2025 at 3:12 PM, Director of Maintenance #1 stated that they contacted the vendor to treat for small flies resident room [ROOM NUMBER], the conference room, and the employee break room. 10 New York Codes, Rules and Regulations 415.29(j)(5)