STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335389	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not protect and promote the rights of the resident; did not provide equal access to quality care regardless of diagnosis or severity of condition; and did not ensure residents had the right to be free of interference from the facility in exercising their right to wear clothing for 3 of 3 residents (Resident #'s 61, 63 and 89) reviewed for resident rights and exercise of rights. Specifically, (a) Resident #61 did not have access to their clothing, and staff who were interviewed stated it was difficult to find clothing that fit Resident #61. (b) For over an hour, Resident #63 was viewable from the hallway wearing a hospital gown with their back and buttocks exposed without any underclothes or briefs on. (c) Resident #89 was noted to smell of feces and wear clothing that was soiled with what looked like feces. This is evidenced by: 48413 Resident #61 was admitted to the facility with diagnoses which included rhabdomyolysis (a condition that causes muscles to break down), post-traumatic stress disorder (a mental health condition that's triggered by an event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event), and schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). The Minimum Data Set (an assessment tool) dated 4/12/2024, documented the resident could be understood and could understand others with a Brief Interview of Mental Status score indicated minimum cognitive impairment for decisions of daily living. Resident #63 was admitted with diagnoses of traumatic subdural hemorrhage (traumatic bleeding near the brain), urinary calculus (hard deposits of minerals and salts commonly called bladder stones), and scoliosis (a sideways curve of the spine). The Minimum Data Set (an assessment tool) dated 4/11/2024, documented that the resident could sometimes be understood and sometimes understand others and sometimes follow direction. The Brief Interview of Mental Status score indicated the resident had significant cognitive impairment for decisions of daily living. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89 was admitted with diagnoses of Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), disorders of bone density and structure, and dementia with agitation (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). The Minimum Data Set (an assessment tool) dated 2/25/2024, documented that the resident could be understood and understand others and follow direction. The Brief Interview of Mental Status score indicated the resident had severe cognitive impairment for decisions of daily living. A facility policy titled Residents' Rights dated 8/2022, documented [NAME] Hills Nursing and Rehabilitation was committed to providing a compliant and respectful environment. Residents of [NAME] Hills have the Right (including but not limited) to dignity, respect, and a comfortable living environment; quality of care and treatment without discrimination; freedom of choice to make their own, independent decisions. During an observation on 5/13/2024 at 10:15 AM, Resident #63 was observed in bed with the door opened, privacy curtain also opened. Resident #63's buttocks was exposed, no underwear or brief, and was wearing hospital gown. During an observation on 5/13/2024 at 11:30 AM, Resident #63 was still wearing hospital gown in bed. 48615 During unit observations on 5/13/2024 at 10:15 AM, Resident #63 was observed from the hallway, in bed, door and privacy curtain opened, wearing a hospital gown with their back and buttocks exposed without any underclothes or briefs on. Resident #63 was observed still wearing hospital gown, with exposed back and buttocks in their room at 11:30 AM. During unit observations on 5/13/2024 at 12:40 PM, Resident #89 was observed wandering about the unit and in other resident rooms. Resident #89 was noted to smell of feces, have socks soiled with what looked like feces, and wore an incontinence brief that looked to be heavily saturated and smelled of feces. During initial interviews on 5/14/2024 at 11:19 AM, Resident #61 stated that they were made to wear a hospital gown because their clothes were dirty, and no laundry service had been done. Resident #61 stated they had been wearing the same hospital gown for two days and was not very happy about it. Resident #61 stated they would rather wear regular clothes. During an interview on 5/16/2024 at 12:52 PM, Resident #61 stated that the staff did not have any other clothes for them due to the resident's size. Resident #61 also stated that staff had not offered to go and purchase any clothing and that they did not like to be in the hospital gown. Resident #61 was observed 4 days in a row wearing a hospital gown. On day 4, the facility provided a second hospital gown to wear backwards, enabling the resident's bare back not be visible. The previous 3 days, this had not occurred. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/17/2024 at 8:44 AM, Certified Nurse Assistant #3 stated that clothes from previous residents were kept [NAME] given to residents who did not have clothes or were waiting for laundry to come back. The facility didn't have clothing for residents other than donated clothing or hospital gowns. During an interview on 5/20/2024 at 11:23 AM, Certified Nurse Assistant #3 stated that Resident #61 didn't like the clothing the facility offered, and that it was hard to find clothing that fit the resident. Certified Nurse Assistant #3 stated that they were aware that Resident #61 was upset and aggravated when the resident was forced to wear the hospital gown. During an interview on 5/20/2024 at 12:58 PM, Certified Nurse Assistant #4 stated Resident #61 was a large person and difficult to find clothes for. Certified Nurse Aide #4 also stated that it was possible that the resident had to wear a hospital gown because the resident did not have any laundry on Saturday (5/11/2024), when Resident #61's belongings were due to arrive. Additionally, if Resident #61 had been on their assignment, they would make sure that Resident #61 had two coats on to be covered. Certified Nurse Assistant #4 did not know why the resident body was partially exposed on Monday (5/13/2024) and Tuesday (5/14/2024) and stated that it should not have happened. During an interview on 5/21/2024 at 11:00 AM, Licensed Practical Nurse #4 stated that staff had searched the donated clothing, but nothing fit Resident #61. Licensed Practical Nurse #4 made mention that resident should have had another gown on to wear covering their body and not leaving their back exposed. Licensed Practical Nurse #4 could not give answer as to why Resident #61 was not covered for 2 full days on Monday (5/13/2024) or Tuesday (5/14/2024) during unit observations in both the common area and the hallways of the facility. 10 New York Code of Rules and Regulations 415.5(a)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure residents have the right to and the facility must promote and facilitate resident self-determination through support of resident choice, and that the resident had a right to make choices about aspects of their life in the facility that are significant to the resident for 1 (Resident #80) of 1 resident reviewed Specifically, Resident #80 did not get out of bed due to facility not having the appropriate wheelchair. This is evidenced by: 48615 The facility's Policy and Procedure titled, Resident Rights and effective 8/2022, documented Resident of [NAME] Hills had the Right (including but not limited) to: dignity, respect and a comfortable living environment quality of care and treatment without discrimination freedom of choice to make your own, independent decisions be informed in writing about services and fees before you enter the nursing home the safeguard of your property and money appeal a transfer or discharge with the New York State Department of Health privacy in communications choose your own schedule, activities and other preferences that are important to you receive visitors of your choosing at the time of your choosing an easy-to-use and responsive complaint procedure be free from abuse including verbal, sexual, mental and physical abuse be free from restraints exercise all of your rights without fear of reprisals (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The document titled, Your Rights as a Nursing Home Resident in New York State (NYS), published by the New York State Department of Health, documented under self-determination that the resident had the right to be offered choices and allowed to make decisions that were important to them; to make personal decisions such as what to wear, when to sleep or how to spend free time; and to accept or refuse care and treatment. Resident #80 was admitted with diagnoses of Cerebral Palsy unspecified (group of conditions that affect movement and posture); morbid obesity due to excess calories; unspecified diastolic congestive heart failure (left heart chamber has become stiffer than normal. Because of that, the heart can't relax the way it should). The Minimum Data Set (an assessment tool) of 04/01/2024, documented resident had a moderate cognitive impairment, could be understood and understand others. During an observation on 5/13/2024 at 11:00 AM, and on 5/14/2024 at 11:15 AM, Resident #80 was in bed wearing a hospital gown, watching a movie on their cell phone. During an interview on 5/15/2024 at 10:30 AM, Resident # 80 stated they do not get out of bed because no one gets them out of bed. Resident #80 stated they do not have a wheelchair that fitted them. They had asked for a wheelchair over and over for months. They were given a geriatric chair and resident refused this chair. Resident #80 stated they were unable to self-propel a geriatric chair. They were given a standard wheelchair that was too small in width for comfort. Resident #80 stated they no longer attended therapy, it was discontinued. They would like to go to the gym. Resident had limited lower body movement but had full upper body strength. Resident was alert and oriented to person, place, and time. During an interview on 5/15/2024 at 12:15 PM, Certified Nurse Aide #6 stated, they did not offer to get Resident #80 up because they always refused. During an interview on 5/15//2024, Licensed Practical Nurse #2 stated Resident never get out of bed because they refused. On 5/15/2024 at 4:00 PM, Resident #80 was moved from South unit to East Unit. Resident stated not sure why they were moved, but they were very happy to be on the East Wing, which was the subacute rehabilitation unit. During an interview on 5/16/2024 at 9:45 AM, Director of Rehabilitation #1 stated Resident #80 had plateaued and was no longer receiving therapy. They were given a geriatric wheelchair due to their diagnosis of cerebral palsy and requirement to tilt back when in chair. Resident refused geriatric chair as they were unable to self-propel using a geriatric chair. Another wheelchair was offered, and resident declined stating it was too tight. This was the standard wide chair with high back. Director of Rehabilitation #1 stated Resident with special needs could have custom size (bariatric) wheelchairs ordered. During an observation on 5/17/2024, Resident #80 was noted to have received a high back wheelchair that met their needs for width and self-propelling. Resident attended gym session and was told they could go to gym at any time. Resident was observed out of bed self-propelling in corridor and also noted to spend time in gym independently. 10 New York Codes, Rules and Regulations 415.5(b)(1-3)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 48744 Based on observations, interviews and record review conducted during the Recertification Survey, the facility did not ensure that all residents had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive (medical interventions in the event of a life-threatening episode) that would be honored for 1 (Residents #316) of 1 resident reviewed. Specifically, Resident #316's advance directive (code status) identifiers were not consistently documented to reflect Medical Orders for Life-Sustaining Treatment orders that could be easily identified by for all staff. This is evidenced by: 48413 Resident # 316 was admitted to the facility with the diagnoses of unspecified dementia, without behavior disturbances, early onset of Alzheimer's disease, and type 2 diabetes. The Minimum Data Set (an assessment tool) dated documented the resident had severe cognitive impairment, could understand others and make themselves understood. A review of the facility's policy and procedure titled, Medical Order for Life-Sustaining Treatment and revised on 6/2023, documented the purpose was to ensure that all residents received person-centered care with respect and dignity, with end-of-life wishes acknowledged and honored, in a manner consistent with best practice and prevailing State and Federal regulations. The policy documented that the resident's Advance Directives would be maintained in the care plan, as a physician order, on the resident ID band (cross-reference Identifying Code Status Policy), in Social Work progress notes, and on the Medical Order for Life-Sustaining Treatment. A review of medical orders from 5/10/2024 documented phone orders from Medical Director #1 for Resident #316 for their code status as a Do Not Resuscitate/Do Not Intubate. A review of social work progress notes dated 5/12/2024 at 11:45 AM, documented resident had a Cardio-Pulmonary Resuscitation code status. During an observation on 5/14/2024 at 10:59 AM, Resident was a 'Do Not Resuscitate' per their Medical Order for Life-Sustaining Treatment reviewed in their medical chart. No Medical Order for Life-Sustaining Treatment information was in the resident's electronic records. Resident #316 did not have an identification bracelet on them at the time of observation. During an interview on 5/20/2024 at 12:05 PM, Certified Nurse Aide #3 stated that residents' code status was located on their Medical Order for Life-Sustaining Treatment in their chart. They stated that the code status was located on the resident ID bracelet as well and should also be in the resident electronic chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2024 at 1:06 PM, Certified Nurse Aide #4 stated that residents' code status was located on the resident identification bracelet as well and should also be in the resident electronic chart. They notified the unit nurse if they noticed a resident was unresponsive. During an interview on 5/21/2024 at 11:25 AM, Licensed Practical Nurse #4 stated that residents' code status was located on their Medical Order for Life-Sustaining Treatment in their chart. They stated that the code status was located on the resident ID bracelet as well and should also be in the resident electronic chart. They stated that the residents sometimes took their bracelets off of them and staff would find them on the floor, under the bed, in the bathroom, or sometimes not at all depending on when and where they took it off. They stated that they wee not sure why the advance directive was not in the electronic records as of yet since the medical provider signed off on the Medical Order for Life-Sustaining Treatment last Friday 5/17/2024. They stated that the resident was a full code, which means the resident required Cardio-Pulmonary Resuscitation. They stated that they remembered doing the informational meeting for the Medical Order for Life-Sustaining Treatment with the resident and the family upon admission to the facility. Licensed Practical Nurse #4 stated that the Medical Order for Life-Sustaining Treatment gets scanned in the system after the medical provider reviews and signs off on the document. They stated that the process from the initial meeting to having the document scanned and placed in the system usually took about 48 hours. They stated that the process for an advanced directive was: 1) They would do the advanced directive review upon resident arrival to the facility with the resident if they were alert and cognitively intact. 2) If the resident was not alert or cognitively intact then they would call the family or resident representative and discuss the document and resident wishes with them. 3) The provider then reviewed the document usually within 24 hours. They stated that they would leave it in the doctor review folder at the front desk. 4) Once the medical provider reviewed and signs off on the document the unit clerk or administrative assistant scanned it into the electronic records within 24 hours. They stated that all updates for advanced directives should be updated on the bracelet and in the system when the resident or family member had made a change to their code status. In a subsequent interview on 5/22/2024 at 10:35 AM, Licensed Practical Nurse #4 stated that the Medical Order for Life-Sustaining Treatment form was now scanned into the system and the electronic records were updated to reflect the Medical Order for Life-Sustaining Treatment documented code status. They stated that they were unsure why the document was not scanned but they would make sure that they would be scanned in the future. During an interview on 5/22/2024 at 10:43 AM, Director of Nursing #1 stated that all advanced directives should be done during the admission process. They stated that depending on resident cognition they should have a discussion on advanced directives or family representative within 24 hours of the resident arriving at the facility. They stated that the Medical Order for Life-Sustaining Treatment should be completed, and reviewed, with the medical provider signing the document within 48 hours. Then the document needs to be placed in the front of the resident's chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules and Regulations 415.3(f)(1)(ii)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not ensure that the facility did not exercise reasonable care for the protection of the resident's property from loss or theft for 4 (Residents #1, 34, 73, and 108) of 4 residents reviewed for missing property. Specifically, Residents #1, 34, 73, and 108 personal belongings sent out for laundering were not returned to the residents timely. This is evidenced by: 48615 A facility policy titled, Personal Property Theft and Loss Risk and dated October 2023, documented the facility provided for the reasonable safekeeping of personal property and funds for residents in the facility per state and federal requirements. The policy further documented that the facility provided labeling of the resident's clothing and personal property. Additionally, all resident property was to be listed on the inventory record and updated when new items were obtained. Resident #1 was admitted with diagnoses of Waldenstrom Macroglobulinemia (a slow growing type of non-Hodgkin lymphoma), nutritional anemia, and generalized anxiety disorder. The Minimum Data Set (an assessment tool) dated 5/03/2024, documented that the resident was cognitively intact, could be understood and understand others. Resident #34 was admitted to the facility with diagnoses which included unspecified dementia, major depressive disorder, and cerebral infarction. The Minimum Data Set, dated dated dated [DATE], documented the resident had significant impaired cognition, could usually be understood and could understand others. Resident #73 was admitted with diagnoses of atherosclerotic heart disease, cachexia (muscle loss, and severe protein-calorie malnutrition. The Minimum Data Set, dated dated dated [DATE], documented that the resident was cognitively intact, could be understood and understand others. Resident #108 was admitted with diagnoses of dementia, displaced fracture of proximal phalanx of left index finger, and diverticulosis of intestine. The Minimum Data Set, dated dated dated [DATE], documented that the resident was cognitively impaired, could be understood and usually understand others. Facility grievances filed in April 2024, of which there were 4, only one involved missing item, and it was documented to have been returned. There was no description of what was missing. During an observation on 5/13/2024 a new resident was admitted . They were observed to have two bags of belongings. Further observations revealed that the resident had clothing in their dresser that was not labeled. The resident stated no one had inventoried their belongings. No inventory sheet was located in the paper chart or in point click care. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/21/24 at 4:05 PM, the dresser observed on 5/13/2024 was still full of clothing and noted to not have any labels. During observations on 5/21/2024 at 11:44 AM. Resident #108's closet was noted to have one tee shirt labeled with resident's name. The rest of the resident's clothing had no label. During initial interview on 5/13/2024 at 11:06 AM, Resident #73 stated that they were missing personal laundry. When asked if they had filed a grievance regarding missing items, the resident stated that they never filed a grievance because the facility would not do anything. During initial interviews on 5/13/2024 at 12:20 PM, Resident #1 stated that clothing had gone to laundry and did not come back. Resident #1 further stated that they had asked Director of Environmental Services #1 about the missing items, but never filed a grievance. Some of the clothing was returned after being missing for roughly 3 weeks. During an interview on 5/16/2024 at 12:00 PM, Certified Nurse Aide #1 stated laundry was done off site. The receptionist made sure that clothing were labeled with the resident's name and room number. Certified Nurse Aide #1 stated that dirty laundry was put in mesh bags and that each wing had a different colored bag. The laundry bags were collected and put in a bin in the dirty utility room in a white bucket that was labeled window and door (bed side. The laundry was and picked up on Tuesdays. Certified Nurse Aide #1 stated they assume that housekeeping took them from the dirty utility room to the truck that came to take the laundry to where laundry was done. Clean laundry was brought back on hangers (underwear and socks in the mesh bags) with a cart that had rods and rolled through the unit to be passed out. They stated they had someone that passed out the laundry but not sure where they have been lately. They stated If a resident reported that they were missing laundry, they would call Director of Environmental Services #1or housekeeping. Certified Nurse Assistant #1 stated they used to inventory resident's belongings when they were admitted and believed that staff were supposed to inventory belongings when resident's came in on paper and the paper was supposed to be in the chart. During an interview on 5/17/2024 at 10:23 AM, Licensed Practical Nurse #3 stated that when someone was admitted to the unit, it was usually from another unit. If the resident was new to the building, the process should be that the resident's stuff went to receptionist who labeled them and filled out the inventory sheet. Licensed Practical Nurse #3 stated that the staff do not check the inventory sheet when people were transferred to the unit or to another unit. The inventory list was kept in the paper chart and was supposed to be updated when more stuff came for the resident. During an interview on 5/17/2024 at 10:49 AM, Licensed Practical Nurse #4 stated clothing was given to receptionist to be inventoried and labeled. Anything that needs to be plugged in is sent to maintenance to be checked and inventoried. These inventory sheets could possibly two different sheets. A copy of the inventory sheet sometimes got scanned into electronic medical charting system. If something went missing, the Social Worker or Maintenance was notified. If the items were not found, a staff meeting was held to discuss what actions would be taken regarding the missing items. If a resident was unable to make a complaint for themselves but it was noted that they were missing items, the floor staff might do it for them but usually it fell to the Social Worker. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2024 at 10:57 AM, Receptionist #1 stated personal belongings were supposed to come to reception to be tagged and inventoried, but the process had changed because the labels kept falling off. Now the labels were the iron on kind and Laundry Person #1 was responsible for labeling and inventory of the resident belongings. Receptionist #1 stated the inventory sheets were supposed to be filled out by Laundry Person #1. The inventory sheets were kept at the desk with the receptionist. No one comes to check the sheets when residents change rooms. The staff would come and check the inventory sheets when things were missing. Receptionist received emails regarding new admissions and when they were coming. The night receptionist leaves the belongings of new residents or new belongings of current residents in the receptionist office for the day person to bring to Laundry Person #1. Laundry Person #1 was also the person responsible for distributing the clean laundry when it came back. During an interview on 5/21/24 at 1:04 PM, Certified Nurse Aide #5 stated that if a resident complained about missing personal items or issues that could be considered grievance level concern, they would bring it to the nurse on the unit. If that does not resolve the situation, Certified Nurse Aide #5 stated they would take it to a higher leveled staff like the Director of Nursing or the administrator or the social worker. Certified Nurse Assistant #5 stated they do not fill out grievance forms. During an interview on 5/21/2024 at 3:48 PM, Director of Maintenance #1 stated that each unit had their own colored bags. North unit had blue bags and was picked up on Tuesday. East unit had red bags and was picked up on Thursday. South unit had gray bags and was picked up on Saturday. The clothing is dropped off the following laundry day. Tuesday's laundry was brought back on Thursday. Thursday's laundry was brought back Saturday. Every resident had 3 bags. Laundry Person #1 had been hired to receive and distribute laundry. They were also responsible for filling out the sheet and ironing on the label to the clothing. The inventory sheets were kept with the reception desk. Residents were encouraged to send new items they have ordered to be labeled as well as items brought in from family. New items brought in get a new inventory sheet. The sheets were referenced when a resident reported something was missing. Otherwise, typically the inventory sheet was not accessed, for example, if a resident was moved from one unit to another. 10 New York Code of Rules and Regulations 483.10(i)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not ensure that grievances were resolved in a timely manner for 3 (Residents #1, 34, and 73) or 3 residents reviewed. Specifically, resident's concerns were not documented and resolved through the facility grievance process. This is evidenced by: 48413 A facility policy titled, Grievance Reporting and Response and dated 10/01/2022, documented that to make a complaint or a recommendation, fill out a grievance form and put it in one of the grievances boxes located by the Social Work office and on each unit. Forms would be collected and brought to the attention of the Administrator and/or Director of Nursing Services for review and resolution by the appropriate party. Grievances could also be filed verbally with the Director of Social Work or the Administrator. If a grievance included issues involving abuse, neglect, or misappropriation, the administrator and the Director of Nursing would be notified immediately, and an investigation and appropriate reporting would commence as per the abuse/neglect/maltreatment policy. Resident #1 was admitted with diagnoses of Waldenstrom Macroglobulinemia (a slow growing type of non-Hodgkin lymphoma), nutritional anemia, and generalized anxiety disorder. The Minimum Data Set (an assessment tool) dated 5/03/2024, documented that the resident had minimal impaired cognition, could be understood, and understand others and follow direction. Resident #34 was admitted to the facility with diagnoses which included unspecified dementia, major depressive disorder, and cerebral infarction. The Minimum Data Set, dated dated dated [DATE], documented the resident had significant cognitive impairment, could usually be understood, and could understand others. Resident #73 was admitted with diagnoses of atherosclerotic heart disease, cachexia, (muscle wasting) and severe protein-calorie malnutrition. The Minimum Data Set, dated dated dated [DATE], documented that the resident was cognitively intact, could be understood, and understand others. Facility grievances filed in April 2024, of which there were 4, only one involved missing item, and it was documented to have been returned. There was no description of what was missing. The other grievances filed involved a yogurt that was taken from the refrigerator, a lock box that needed repairing, and replacing of an air mattress. During initial interview on 5/13/2024 at 11:06 AM, Resident #73 stated that they were missing personal laundry. When asked if they had filed a grievance regarding missing items, the resident stated that they never file a grievance because it doesn't end up doing anything During initial interviews on 5/13/2024 at 12:20 PM, Resident #1 stated that their clothing had gone to laundry and did not come back. Resident #1 further stated that they had asked the Director of Environmental Services #1 about the missing items, but never filed a grievance. Some of the clothing was returned after being missing for roughly 3 weeks. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council Meeting on 5/15/2024 at 9:43 AM, residents stated that they did not know who was in charge of grievances and that when questions were asked by the residents, the staff respond that it will be looked into but residents did not see resolutions to complaints raised. During an interview on 5/16/2024 at 12:00 PM, Certified Nurse Aide #1 stated if a resident reported to them that they were missing laundry, they would call Director of Maintenance Services #1 or housekeeping. Certified Nurse Aide #1 stated they used to inventory resident's belongings when they were admitted and believed that staff were supposed to inventory belongings when residents came in on paper and the paper was supposed to be in the chart. During an interview on 5/17/2024 at 10:23 AM, Licensed Practical Nurse #3 stated that when someone was admitted to the unit, they were usually from another unit. If the resident was new to the building, the process should be that the resident's stuff goes to receptionist who labels them and fills out the inventory sheet. Licensed Practical Nurse #3 stated that the staff do not check the inventory sheet when people were transferred to the unit or to another unit. Licensed Practical Nurse #3 stated that there was a box and a folder with grievance forms in the hallway. The folder kept getting knocked off the wall, so now the grievance forms were kept in the Licensed Practical Nurse #3's office. The box for the forms was located behind a linen cart on the unit. Licensed Practical Nurse #3 asked a Certified Nurse Aide to move the linen cart so the box could be accessed. When asked the last time someone opened the box to retrieve grievance forms, Licensed Practical Nurse #3 stated that they had never seen someone open the box but them. During an interview on 5/17/2024 at 10:49 AM, Licensed Practical Nurse #4 stated clothing were given to receptionist to be inventoried and labeled. Anything that needed to be plugged in is sent to maintenance to be checked and inventoried. If something went missing, the Social Worker was notified or Maintenance was notified. If the items were not found, a staff meeting was held to discuss what actions would be taken regarding the missing items. If a resident was unable to make a complaint for themselves but it was noted that they were missing items, the floor staff might do it for them but usually it fell to the Social Worker. During an interview on 5/21/24 at 1:04 PM, Certified Nurse Aide #5 stated that if a resident complained about missing personal items or issues that could be considered grievance level concern, they would bring it to the nurse on the unit. If that did not resolve the situation, then they would take it to a higher leveled staff like the Director of Nursing or the administrator or the social worker. Certified Nurse Aide #5 stated they do not fill out grievance forms. 10 New York Code of Rules and Regulations 483.10(i)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interview conducted during the recertification survey, the facility did not ensure Significant Change Minimum Data Set assessment was completed for a 1 (Resident #36) of 1 resident reviewed for significant changes in health status. Specifically, Resident #36 experienced a change in respiratory status, was sent to the hospital on 4/18/2024 and returned on 4/19/2024 with diagnosis of respiratory bronchiolitis interstitial lung disease requiring oxygen and inhaler use. This is evidenced by: 48413 Resident #36: The resident was admitted to the facility on with the diagnoses of chronic obstructive pulmonary disease, respiratory bronchiolitis interstitial lung disease, and type 2 diabetes. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could understand others, and could make themselves understood. The Policy and Procedure titled, Comprehensive Care Plans and dated 9/2023, documented every resident will have an Interdisciplinary Care Plan, with the Interim/baseline Interdisciplinary Care Plan updated or modified between care plan conferences when appropriate to meet the resident's current needs, problems and goals. The Care Plan would be updated and/or revised for any Significant change in the resident's condition or a change in any planned interventions. Physician order date 4/19/2024 documented Ipratropium Bromide inhalation aerosol solution 17 micrograms per actuation. I unit inhale orally route 4 times a day for bronchiolitis and chronic obstructive pulmonary disease. Start day 04/19/2024. Physician order date 4/19/2024 documented Symbicort inhalation aerosol 4.5 micrograms per actuation 2 inhalations inhale orally 2 times a day for chronic obstructive pulmonary disease. Start day 4/19/2024. Physician order date 4/19/2024 documented Albuterol Sulfate inhalation nebulization solution 2.5 milligrams/3 milliliters. Inhale 3 milliliters by inhalation via nebulizer every 2 hours for shortness of breath and wheezing. Start day 4/19/2024. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2024 at 10:41 AM, Licensed Practical Nurse #4 stated documentation should have been added to the resident's care plan for respiratory issues because Resident #36 had a significant change in their respiratory status requiring inhalers and the use of a nebulizer treatment. They stated the resident had been complaining about difficulty in breathing and was sent to the hospital on 4/18/2024 and returned on 4/19/2024 with diagnoses of respiratory bronchiolitis and chronic obstructive pulmonary disease. They stated that the resident is to have the inhalers and nebulizers but were unable to find the care plan located in the resident electronic record. They stated that a care plan should have been initiated as the resident did not have the medications before being sent to the hospital for respiratory distress. During an interview on 5/20/2024 at 11:02 AM, the Minimum Data Set Coordinator #1 stated the resident had a significant change on 4/19/2024 upon readmission from the hospital. They stated that the care plans had to be completed by all involved disciplines within 48 hours of a resident's admission. They stated that the care plans and the Minimum Data Set should have been updated as the resident had a significant change. 10 New York Codes, Rules and Regulations 415.11(a)(3)(ii)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on record review and interviews during a recertification and abbreviated survey (Case #s NY00317289 and NY00325414), the facility did not ensure it developed and implemented a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident within 48 hours of a resident's admission for 1 resident (Resident #115) of 3 residents reviewed for baseline care plans. Specifically, Resident #115 baseline care plan was not completed by staff and signed by the resident within 48 hours of their admission to the facility. This is evidenced by: 35228 The Policy and Procedure titled, Comprehensive Care Plans and dated 9/2023, documented every resident will have an Interdisciplinary Care Plan, with the Interim/baseline Interdisciplinary Care Plan initiated within 48 hours of admission. Resident #115 The resident was admitted to the facility with diagnoses of a fractured back, diabetes, and chronic bladder inflammation. The Minimum Data Set (an assessment tool) dated 10/12/2023, documented the resident had moderate cognitive impairment, could be understood, and could usually understand others. The document titled, Baseline Care Plan, documented Resident #115 was admitted to the facility on [DATE]. It was signed by the resident on 9/19/2023. Licensed Practical Nurse #1 documented they completed the plan on 9/19/2023. During an interview on 5/20/2024 at 11:02 AM, Minimum Data Set Coordinator #1 stated baseline care plans had to be completed by all involved disciplines within 48 hours of a resident's admission. They stated the nurses on the unit reviewed the baseline care plan with the resident upon completion within 48 hours and had resident sign it. They stated if the resident was cognitively impaired, the facility would have to review it with the resident representative or the Health Care Proxy. They stated they were aware that baseline care plans were not always being completed within 48 hours. During an interview on 5/20/2024 at 11:11 AM, Director of Nursing stated #1 baseline care plans needed to be completed within 24 hours, or maybe it was 48 hours. The baseline care plan should be reviewed with the resident within that timeframe. If the resident was unable to review the care plan with staff the resident representative, Power of Attorney, or Health Care Proxy were notified to go over it. 10 New York Codes, Rules, and Regulations 415.11

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not ensure to develop or implement a comprehensive person-centered care plan for each resident for 3 (Residents #1, #23, #63) of 3 residents reviewed for comprehensive person-centered care plans. Specifically, for Resident #s 1 and 23, a care plan was not developed, or interventions implemented for use of anticoagulants (blood thinners). For Resident #63, care plan did not document physician's supervision for significant weight loss or interventions implemented. This is evidenced by: 48615 A facility policy titled Comprehensive Care Plans dated 9/2023, documented that every resident would have an Interdisciplinary Care Plan, with the Interim/baseline Interdisciplinary Care Plan initiated within 48 hours of admission. The care plan would identify priority problems and needs to be addressed by the interdisciplinary team, and would reflect the resident's strengths, limitations, and goals. The care plan would be complete, current, realistic, time specific and appropriate to the individual needs for each resident. There would be ongoing documentation of the nursing process related to resident needs from admission to discharge. The interdisciplinary plan of care would be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It would be consistent with the medical plan of care and those disciplines that had direct involvement with the resident's care. The resident and/or family member would be involved in the care planning. The care plan would contain information about the physical, emotional/psychological, psychosocial, spiritual, educational, and environmental needs as appropriate. The Interim Interdisciplinary Care Plan will be located in the care plan section of the Medical Record. The purpose was to ensure that each resident was provided with individualized, goal-directed care, which was reasonable, measurable, and based on resident needs. A resident's care should have the appropriate intervention and provide a means of interdisciplinary communication to ensure continuity in resident care. Resident #1 was admitted with diagnoses of Waldenstrom Macroglobulinemia (a slow growing type of non-Hodgkin lymphoma), nutritional anemia, and generalized anxiety disorder. The Minimum Data Set (an assessment tool) dated 5/03/2024, documented that the resident had minimal cognitive impairment, could be understood and understand others. Resident #23 was admitted to the facility with diagnoses which included fatty liver, fibromyalgia, and unspecified mood disorder. The Minimum Data Set (an assessment tool) dated 4/12/2024, documented the resident was cognitively intact, could be understood and could understand others. Resident #63 was admitted with diagnoses of traumatic subdural hemorrhage, urinary calculus, and scoliosis. The Minimum Data Set (an assessment tool) dated 4/11/2024, documented that the resident had significant cognitive impairment, could sometimes be understood and sometimes understand others. 48413 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 Comprehensive Care Plan dated 3/06/2024 did not document a care plan with interventions for the blood thinning medication Resident #1 was taking. Resident #23 Comprehensive Care Plan dated 3/14/2024 did not document a care plan with intervention for the blood thinning medication Resident #23 was taking. Resident #63 Comprehensive Care Plan dated 2/11/2024 did not document 17% weight loss were supervised by a physician. Physician progress notes dated 1/1/2024 - 5/21/2024 did not document physician progress of 17% weight loss. 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 - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48744 Based on record review and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions for 1 (Resident #'67) of 1 resident reviewed. Specifically, for Resident #67's\ Comprehensive Care Plan for psychotropic medications was not reviewed and revised after medication changes. This is evidenced by: 48413 Resident # 67 was admitted to the facility with diagnoses of unspecified dementia with agitation, major depressive disorder, and hypertension. The Minimum Data Set (an assessment tool) dated 6/13/2023 documented the resident had moderate cognitive impairment, could understand others, and could make self-understood. A review of Policy and Procedure for Dementia Care, last revised 10/2023, documented that in certain cases and after interdisciplinary considerations a resident may benefit from the use of medication when clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed . Residents who use antipsychotic drugs would receive a Gradual Dose Reduction and behavioral interventions unless clinically contraindicated. The staff would observe, document, and report to the attending physician information regarding the effectiveness of any interventions and report any side effects and adverse consequences of antipsychotic medications to the attending physician. A review of Policy and Procedure for Comprehensive Resident Centered Care Plans, last revised 9/2023, documented it was the policy of the facility to promote interdisciplinary care for the residents by utilizing an interdisciplinary plan of care based on assessment, planning, treatment, service, and intervention. Care plans were modified between care plan conferences when appropriate to meet the resident's current needs, problems, and goals were updated with changes of a new diagnosis, new medications, or abnormal labs. A review of the Medication Administration Records for March 2024 indicated an order for zoloft (sertraline) Oral Tablet 150 milligrams 1 tablet along with zoloft (sertraline) Oral Tablet 25 milligrams 1 tablet for a total of 175 milligrams to be given by mouth daily starting 8/03/2023 and ending on 4/12/2024. A review of the Medication Administration Records for April 2024 indicated an order for zoloft (Sertraline) Oral Tablet 100 milligrams 1 tablet along with zoloft (sertraline) Oral Tablet 25 milligrams 1 tablet for a total of 125 milligrams to be given by mouth daily starting 4/13/2023 and ending on 5/09/2024. A review of the Medication Administration Records for May 2024 indicated a new order for zoloft (sertraline) Oral Tablet 100 milligrams 1 tablet to be given by mouth daily starting 5/10/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the psychiatric medication review dated 4/12/2024 by nurse practitioner documented 150 milligrams by mouth daily with sertraline 25 milligrams by mouth totaling 175 mg daily dose decreased to sertraline 125 milligrams total and will continue to taper as tolerated. No other medication review was conducted after 4/12/2024. A review of the comprehensive care plan dated documented Resident #67 was at risk for alteration in mood due to dementia with behaviors, anxiety, and depression. The last update created by social work was entered on 4/23/2024 and documented that the resident was seen by psychiatry. The last revision of interventions and goals for psychiatry recommendations was entered on 12/22/2023 documented the resident to continue with sertraline of 175 milligrams daily. During an interview on 5/22/2024 at 11:11 AM, Director of Nursing #1 stated the Comprehensive Care Plan should be person-centered and include non-pharmacological interventions and monitoring. The Comprehensive Care Plan should have been reviewed and revised, based on the changing goals, preferences, and needs of the resident and in response to current interventions not reviewed and revised by the interdisciplinary team after each assessment. 10 New York Codes, Rules and Regulations 415.11(c)(2)(i-iii)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48744 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure to complete a comprehensive assessment of a resident, to receive treatment and care in accordance with professional standards of practice for 1 (Resident #89) of 1 resident reviewed Specifically, Resident #89's standing order for compression stockings was not carried out and staff stated compression stockings were never placed because the resident would take them off. This is evidenced by: 48615 Resident #89 was admitted with diagnoses of Alzheimer's Disease (a disorder of brain causing dementia, impaired ability to think or make decisions), Atherosclerotic Heart Disease (the buildup of fats, cholesterol, and other substances in and on the artery walls), and depression. The Minimum Data Set (an assessment tool) dated 02/25/2024, documented resident had severe impaired cognition a Brief Interview of Mental Status score assessed them with severe cognitive impairment. The facility Policy and Procedure titled, Comprehensive Care Plans and revised 9/2023, documented comprehensive care plan would be Developed within 7 days after completion of the comprehensive assessment and address specific care areas (focuses) as identified. The services provided or arranged by the facility, as outlined by the comprehensive care plan, would meet professional standards of quality. Each discipline will check and/or add interventions/approaches to include but not limited to: a. The intervention statements describe those measures performed by the staff to help the resident achieve the expected outcomes b. Interventional entries reflect activities that incorporate observations, assessments, management, and teaching components that would restore, maintain and/or promote the resident's well-being. c. Each planned intervention would be specific and include parameters for frequency and time schedule. 4. Each discipline would check or add expected outcomes and goals. Expected outcomes describe the realistic short-range goals to be achieved by the resident within a specific time frame. 5. These activities would be completed for each patient problem. During an observation on 5/13/2024 to 5/22/2024, Resident #89 was noted to have 2+ bilateral lower extremity edema (swelling). The Medication Administration Record dated May 2024 documented apply compression stockings to bilateral lower extremities daily for edema with an effective date of 11/14/2023. Resident #89 was observed wearing non-skid socks without compression stockings. There were notable indentations on lower legs left from non-skid socks. A physician note dated 1/03/2024 documented vital signs stable, last weight 136.4 pounds, Ideal Body Weight 120 pounds, resident had significant lower extremity edema. Care Plan dated 4/09/2024 documented monitor and report cardiac symptoms: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in cap refill, color/warmth of extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/2024 at 09:47 AM, Director of Nursing #1 stated Resident 89's order for compression stockings should had been discontinued because Resident #89 was non-compliant and removed them secondary to their dementia (impaired ability to think or make decisions). They stated a new Nurse Practitioner started on 5/20/2024 who would assess the needs of residents at the facility. Orders were reviewed quarterly. During an interview on 5/22/2024 at 10:30 AM, Licensed Practical Nurse #2 stated standing routine orders had not been reviewed in a while. They reviewed orders with the physician about three months ago. Licensed Practical Nurse #2 stated due to several changes in leadership many things had been missed. Resident #89's compression stockings were never placed because resident would take them off. During an interview on 5/22/2024 at 2:01 PM, Nurse Practitioner #1 stated they started at this facility two days ago and they believed they were to assess residents monthly, and with any change in condition. Nurse Practitioner #1 stated they would assess resident with edema, review medical history, medication history, order labs, imaging, and medication change if needed. 10 New York Codes Rules and Regulations 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that it provided a residential environment that was as free from accident hazards as possible, and that each resident received adequate supervision to prevent accidents for 1 (Resident #36) of 1 resident reviewed for accident hazards. Specifically, Resident #36 was observed using tobacco in their room without supervision; approach was utilized to communicate observed hazards related to the accessibility of the resident's use of tobacco supplies, and the facility did not develop and implement an individualized care plan to address the resident's potential or actual non-compliance with the facility's smoking policy. This is evidenced by: 48413 Resident #36: The resident was admitted to the facility on with the diagnoses of chronic obstructive pulmonary disease, respiratory bronchiolitis interstitial lung disease, and type 2 diabetes. The Minimum Data Set documented the resident was cognitively intact, could understand others, and could make themselves understood. The policy and procedure titled, Smoking Policy and last reviewed on 1/01/2024, documented it was the goal of the facility to provide a safe environment for residents, visitors, and staff by allowing smoking at the facility under close supervision at designated times and locations. The policy documented the residents were not permitted to smoke in the facility, and possession of lighters/matches, or tobacco products of any kind was not allowed on the facility property by residents. The comprehensive care plan for hypertension, last revised on 4/19/2024, documented that hypertension was related to an inappropriate diet and smoking. The care plan did not include interventions to address the resident's potential or actual non-compliance with the facility's smoking policy. The care plan did address Resident #36 as a smoker and was to only smoke under supervision at designated times. The resident was not allowed to have any tobacco products on their person not supervised by staff. A review of nursing progress notes dated 5/12/2024 at 1:02 PM documented the resident came out of their room and accused staff of taking their tobacco and gum. The nurse educated and reminded Resident #36 to move around their belongings before accusing staff of stealing. The resident went back into their room and found their tobacco and gum underneath their sheets. The most recent Smoking assessment dated [DATE], documented the resident smoked daily and was determined to be safe to smoke with supervision. The medical record did not include subsequent smoking assessments before 5/14/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2024 at 12:23 PM, Resident #36 stated that they were allowed to smoke at the facility. They were only allowed to smoke at planned times throughout the day. They stated that they never have any tobacco products in their room, and it was always kept with the facility. During a subsequent interview on 5/16/2024 at 12:50 PM, Resident #36 was observed using chewing tobacco in their room and had a spittoon cup in their hands. In asking the resident if they were allowed to use tobacco in their room they confirmed and stated they were as long as they did not go out of the room with the tobacco juice cup. During an interview on 5/20/2024 at 11:18 AM, Certified Nursing Aide #3 stated that the resident was self-sufficient and does everything themself. They stated that the resident did smoke and had not witnessed the resident smoking in their room. They stated that the resident sometimes had cigarettes on them and was reminded that they were not allowed to have them unsupervised and unlocked with staff. They stated that the resident had chewing tobacco at times and explained to the resident that they should give it to the nurse as it was a violation of the policy. They stated that the resident gets irate and upset when reminded that they were not allowed to have tobacco products. During an interview on 5/20/2024 at 12:45 PM, Certified Nursing Aide #4 stated that the resident smoked and goes out at the designated times and had never been witnessed in room smoking. They stated that they had never seen the resident with cigarettes. They have seen the resident using chewing tobacco at times and seen the tobacco spittoon on the resident's stand. They stated that it was a potential hazard since a resident could come into Resident #36 room and mistake it for a drink. They had mentioned to Resident #36 that they should not have tobacco products in their room and should give them to the nurse. They stated that they had told Licensed Practical Nurse #4 about what they had witnessed. During an interview on 5/21/2024 at 10:34 AM, Licensed Practical Nurse #4 stated that the resident was a nicotine user and goes out at designated times for predetermined smoke breaks. They stated that the resident used chewing tobacco as well and had been caught using tobacco in their room witnessing the tobacco spittoon on the resident's stand. They stated that chewing tobacco was treated like cigarette tobacco and residents were not allowed to have this in their rooms as it was against the smoking policy. They stated it was a concern that the resident had tobacco in their room due to other residents wandering on the unit. They stated the staff on the unit were supposed to check on the resident when they returned to the unit after being out with family but sometimes when no one was around when they returned, the resident would quickly go to their room to hide the tobacco. They stated staff would find the tobacco supplies when the resident left them out and visible in their room. During an observation on 5/21/2024 at 12:14 PM, Director of Nursing #1 stopped next to the surveyor in the hall and stated that they confiscated 4 canisters of chewing tobacco from the resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 10:15 AM, Music Therapy Director #1 stated they were usually the individual who came out during the day and supervised the residents at their designated smoke breaks. They stated that the residents 'were assessed for smoking when they were admitted or in any change that they would like to smoke and sign a contract for smoking. They stated that the residents are allowed only 2 cigarettes at break time and are not allowed to light on their own. Cigarettes were usually paid for by the resident or brought into the facility by family. All tobacco products were to be securely locked in a cabinet and residents were not allowed to have them in their room. There were smoking aprons and fire extinguishers in the cart in cases of emergency. They stated that they attempt to keep track of the residents smoking the cigarettes and if a resident did not completely smoke them, they were to return the unused portions of the cigarettes to them. On occasion, residents have smuggled cigarettes into the facility but has not been the usual ones they had smoked before. During an interview on 5/22/2024 at 10:43 AM, Director of Nursing #1 stated that they had never had to do room searches for residents before up until recently. They stated that usually if a resident brought tobacco products into the facility from outside, they were good about telling staff and abiding by the policy. Residents were dismissed from being able to smoke if they violated the policy. They stated that residents were allowed to use tobacco products as directed in the policy which was at designated times and location. They stated that residents were not allowed to have any tobacco-related products in their rooms. 10 New York Codes, Rules and Regulations 415.12(h)(1)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not ensure that resident care was supervised by a physician for their immediate need for 1 (Resident #63) of 1 resident reviewed for physician care. Specifically, Resident #63 had a significant amount of weight loss and did not receive adequate medical supervision to intervene. This is evidenced by: 48615 Resident #63 was admitted with diagnoses of traumatic subdural hemorrhage, urinary calculus, and scoliosis. The Minimum Data Set (an assessment tool) dated 4/11/2024, documented that the resident had significant cognitive impairment, could sometimes be understood and sometimes understand others. A facility policy titled, Visiting Consultant Visits and dated 9/2023, documented visiting consultants will be vetted per Federal and State guidelines for credentialing and provided with HIPAA compliant access to the Electronic Medical Record. They will be oriented to facility, unit, room, and care team prior to and ongoing during period of provision of services. Appropriateness of visiting consultant visit vs outside consult will be determined by Interdisciplinary Care Provider team. Considerations include complexity of care and potential diagnostic equipment needed as well as resident physical ability to tolerate outside appointment. If visiting consultant was available for the services needed, and it was deemed appropriate, this would be preferred modality for consult. Order is entered per Medical Doctor/Nurse Practitioner to medical record indicating consult type. Nursing will coordinate provision of visit list, pertinent records, and room location with visiting consultants. Upon completion of consultation rounds, documents generated (encounter reports, recommendations) would be provided to Facility by agreed-upon format (hard-copy reports, electronic files etc.) within time frames that were compliant with best practice and prevailing regulations. Documentation would be reviewed for recommendations and new impressions or diagnoses. The Medical Doctor/Nurse Practitioner would be notified of recommendations and orders implemented per their directions. A nursing note should be entered to document consult, results of visit and orders received. If appropriate given resident's mentation and Health Care Proxy wishes, family would be updated regarding the outcome of the consultation. A facility policy titled, Notification of Change in Condition and dated 11/2022, documented a resident's designated representative would be notified of any change in a resident's condition. For example, with physician order change to medications; with any incident/accident occurrence; with change in condition of skin; with any noted significant change in function, behavior, or weight; with any change in medical status indicating need for evaluation at acute care setting; in the event of alleged or suspected resident rights concerns; in accordance with specific request of designated representative or resident. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive Care Plan for potential for Inadequate Oral Intake dated 5/04/2023 documented that the resident had potential for inadequate oral intake related to impaired cognition as evidenced by medical history of dementia. Multiple nutritional risk factors were noted as well as interventions that included but were not limited to providing the current diet ordered, encouraging meals and fluids, with assistance as needed, offering meal substitutes if the resident did not consume more than 50% of their meal and monitor weight trends, diet adequacy and tolerance. Additionally, the care plan interventions listed included Monitor, record and report to the medical doctor signs and symptoms of malnutrition like emaciation (abnormally thin or weak), muscle wasting and significant weight loss such as 3 pounds in a week, 5% in a month, 7.5% in 3 months and 10% in 6 months. During lunch observations on 5/21/2024 at 12:50 PM, Resident #63's lunch tray was noted to have very small portions of non-appetizing appearing food and the meat appeared not fully cooked. The following observations of the meal were as follows: - pudding which did not taste like pudding and was not sweet. - mashed potatoes were salty. - ground meat which was very salty and did not taste like meat. During record review on 5/14/2024 at 10:25 AM, records documented that Resident #63 had a 17.45% weight loss between 12/04/2023 and 4/15/2024. There were two notes from dietary on 1/22/2024 and 4/09/2024. Both notes indicated a significant weight loss and dehydration were present at the time of both notes. Dietary note undated documented most recent weight of 138 pounds (1/15/2024) indicated 24 pounds, 14. 8% weight loss less than 6 months. There was no documented evidence that the physician was notified of the significant weight loss. Physicians' note dated 3/22/2024, did not document Resident #63's weight loss concerns. A nursing health status note dated 3/31/2024 at 2:04 PM documented that the resident required total assistance with meals, ate 50% for breakfast and 25% for lunch. During an interview on 5/21/2024 at 11:00 AM, Registered Dietician #1 stated they reviewed resident food preferences with them. They stated they based their care plan based on what the resident, staff, members of the interdisciplinary team tell them and on record review. 10 New York Code of Rules and Regulations 415.15(b)(1)(i)(ii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48744 Based on observations, record reviews and interviews during the recertification survey, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Specifically, the facility did not perform the appropriate competency evaluations for the licensed nursing staff to measure the pattern of knowledge, skills, abilities, behaviors and other characteristics that an individual needs to perform work roles or occupational functions successfully. This is evidenced by: Resident #73 was admitted with diagnoses of atherosclerotic heart disease, cachexia, and severe protein-calorie malnutrition. The Minimum Data Set (an assessment tool) dated 4/28/2024, documented that the resident could be understood and understand others and follow direction. The Brief Interview of Mental Status score was assessed to be 15/15 which was indicative of no impairment for decisions of daily living. During an observation on 5/16/2024 at 10:26 AM, Resident #73 was noted to have 4 inhalers in their room. The resident stated that one inhaler was from the hospital and was garbage, two of the same type of inhaler were on the bedside table (which the resident stated was because one was almost empty and the other one was its replacement, and 1 rescue inhaler was noted to be on the resident's bed. The resident stated there was no way they would be able to wait for the staff to bring the rescue inhaler to them, so they won't turn them over to the staff. During an observation on 5/17/2024 at 09:00 AM, Resident #73 was noted to have two inhalers on their bed. During an observation on 5/21/2024 at 11:33 AM, Resident #73 was noted to have two inhalers on the bedside table of their room. During an observation on 5/16/2024 at 10:20 AM, the Medication Room on East Unit refrigerator contained a 24-hour urine specimen stored in same refrigerator with multiple resident medications including insulin pens; insulin vials, and glatiramer acetate. Resident #24's right upper arm had a Peripherally inserted central catheter (a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the right side of the heart called the superior vena cava) dressing. The Medication Administration Record dated May 2024 documented change dressing every Wednesday and as needed. Registered Nurse #1 signed Medication Administration Record on 5/15/2024 that indicated Peripherally inserted central catheter dressing was changed. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/16/2024 at 2:13 PM, the right upper arm Peripherally inserted central catheter dressing for Resident #24 was peeling away from skin; edges of dressing were curled with soil along edges; dressing was not dated; double lumen lines were dangling and tucked behind resident. During an interview on 5/22/2024 at 10:30 AM, Licensed Practical Nurse #2 stated standing routine orders had not been reviewed in a while. They reviewed orders with the physician about three months ago. Licensed Practical Nurse #2 stated due to several changes in leadership many things had been missed. Resident #89's compression stockings were never placed because resident would take them off. During an interview on 5/23/2024 at 10:07 AM, Staff Development Nurse #1 stated that they just took this position and was working on setting up new processes to have a better idea of what educations were needed. Staff Development Nurse #1 stated that educations on grievances were handled through the Director of Nursing and Social Work, care planning was done by registered nurses, and specimens should never be stored with medications or food. Additionally, the Staff Development Nurse #1 stated that there will be orientation competencies going forward, one for registered nurses and one for certified nurse assistants. At the time of the interview, there was no process for new hires to determine the level of competency the staff member came with. When asked what the staff would do if there was a need for a registered nurse but there were only licensed practical nurses available, the Staff Development Nurse #1 stated that a registered nurse would come from home. The Staff Development Nurse #1 was unable to list how many nurses were working in the facility but was able to name 6 registered nurses on staff. Staff Development Nurse #1 also stated that there were no competencies for their job when they were hired either. On 5/23/2024 at 10:07 AM, surveyor requested to see the policies and procedures that staff were to utilize, however, there was no binder or digital completion available. There was no documented evidence of online completed competencies available for staff learning. During an interview on 5/23/2024 at 10:26 AM, Registered Nurse #2 stated that they did receive basic training on codes and what they mean but was unsure when that training occurred, but it was under a former Director of Nursing, who was two directors ago. When asked if there were any competencies done when they were hired, Registered Nurse #2 stated that they watched a medication pass and 'some other things.' Registered Nurse #2 stated that an outside vendor came in 3 months ago to show staff how to do a wound vac dressing. Registered Nurse #2 stated that they did not recall any competency related to central line dressing changes; antibiotic administration was considered part of medication training that was expected to have occurred in nursing school. Registered Nurse #2 stated that all specimens should be kept in their own refrigerator, care planning or updating is done by either the MDS coordinator and the unit managers. Registered Nurse #2 stated that central line dressings were done weekly. Registered Nurse #2 verbally described the correct procedure to change a central line dressing. 10 New York Codes, Rules and Regulations 415.26(c)(1)(iv)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record reviews and interviews during recertification survey, the facility did not ensure that the drug regimen of each resident were reviewed at least once a month by a licensed pharmacist for 4 (Resident #'s 23, 78, 30, 67) of 4 residents reviewed. This is evidenced by: 48413 Resident #23 was admitted to the facility with diagnoses of fatty liver, fibromyalgia (a chronic condition where there is heightened pain and widespread pain), and unspecified mood disorder. The Minimum Data Set (an assessment tool) dated 4/12/2024, documented the resident was cognitively intact, could be understood and could understand others. Resident #78 was admitted to the facility with diagnoses of chronic systolic congestive heart failure, acquired deformity of right lower leg and major depressive disorder severe with psychotic symptoms. The Minimum Data Set, dated dated dated [DATE], documented the resident had minimal cognitive impairment, could be understood and could understand others. Resident #30 was admitted to the facility with diagnoses of absence of right leg above knee, chronic total occlusion of artery of the extremities, and atherosclerosis of native arteries of extremities with rest pain and gangrene right leg. The Minimum Data Set, dated dated dated [DATE], documented the resident had significant cognitive impairment, could be understood and could understand others. Resident #67 was admitted to the facility with diagnoses of unspecified dementia with agitation, major depressive disorder, and post-traumatic disorder. The Minimum Data Set, dated dated dated [DATE], documented that the resident had significant, could be understood and understand others. Residents #23, #78, #30, and #67 were all observed interacting with staff and other residents in respectful ways without observations of being overmedicated or appearing to be suffering maladies related to medications being administered by nursing staff. An undated facility policy titled, Mediation Regimen Review, documented that the consultant pharmacist was to perform a comprehensive medication regimen review at least monthly. Findings and recommendations were to be reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator. Additionally, the policy documented that if resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented on a Medication Regimen Review form and reported to the Director of Nursing, and/or physician as appropriate. Resident #23's progress notes reviewed for Medication Regimen Reviews, documented that the last 3 reviews were performed on 1/30/2024, 10/31/2023, and 10/19/2023. Upon request for Monthly Medication Regimen Reviews from the Assistant Administrator #1, the following was provided to the surveyor: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A Consultant Pharmacist Medication Regimen Review dated 2/26/2024, - A Monthly Progress Note dated 3/22/2024 signed by Physician #1. - A Consultant Pharmacist Medication Regimen Review dated 3/17/2024, - A Monthly Progress Notes dated 3/22/2024 signed by Physician #1. The drug regimen of Resident #23 was not reviewed at least once a month by a licensed pharmacist for the months of April 2024, December 2023, November 2023. Resident #78's progress notes reviewed for Medication Regimen Reviews, documented that the last 2 reviews were performed on 1/30/2024 and 10/23/2023. Upon request for Monthly Medication Regimen Reviews from Assistant Administrator #1, the following was provided to the surveyor: - A Consultant Pharmacist Medication Regimen Review dated 3/17/2024, - A Monthly Progress Note dated 2/22/2024 signed by Nurse Practitioner #1. - A Consultant Pharmacist Medication Regimen Review dated 2/26/2024, - A Monthly Progress Note dated 2/22/2024 signed by Nurse Practitioner #1. The drug regimen of Resident #78 was not reviewed at least once a month by a licensed pharmacist for the months of April 2024, March 2024, December 2023, November 2023. Resident #30's progress notes reviewed for Medication Regimen Reviews, documented that the last reviews were performed on 2/26/2024, 10/31/2023, and 10/19/2023. Upon request for Monthly Medication Regimen Reviews from Assistant Administrator #1, the following was provided to the surveyor: - A Consultant Pharmacist Medication Regimen Review dated 4/14/2024, - A Monthly Progress Note dated 3/22/2024 signed by Physician #1. - A Consultant Pharmacist Medication Regimen Review dated 2/26/2024, - A Monthly Progress Notes dated 3/22/2024 signed by Physician #1. The drug regimen of Resident #30 was not reviewed at least once a month by a licensed pharmacist for the months of January 2024, December 2023, November 2023. Resident #67's progress notes reviewed for Medication Regimen Reviews, documented that the last reviews were performed on 1/30/2024, 10/31/2023, and 10/19/2023. Upon request for Monthly Medication Regimen Reviews from Assistant Administrator #1, the following was provided to the surveyor: - A Consultant Pharmacist Medication Regimen Review dated 3/17/2024, - A Monthly Progress Notes dated 3/18/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A Consultant Pharmacist Medication Regimen Review dated 2/26/2024 without an accompanying progress note. The drug regimen of Resident #67 was not reviewed at least once a month by a licensed pharmacist for the months of April 2024, December 2023, November 2023. During an interview on 5/22/2024 at 1:50 PM, Director of Nursing #1 stated that the Medication Regimen Reviews were sent through email, and they received emails weekly. Director of Nursing #1 also stated that the reviews were put in the Medical Provider book if follow up was needed or to the unit manager, and were uploaded to the electronic record system used by the facility. Director of Nursing #1 stated that they believed the reviews should be done on admission, quarterly, or if there is a change in condition. The pharmacist who came in 2-3 times a month completed the reviews and went through the medication carts. During an interview on 5/22/2024 at 2:00 PM, Registered Nurse #1 stated that medication regimen reviews were done on admission, when there were changes in medications or conditions, readmissions, or if something needed to be renewed. During an interview on 5/22/2024 at 2:06 PM, Pharmacist #1 stated that they did the Medication Regimen Reviews monthly and emailed them to the Director of Nursing when completed. 10 New York Code of Rules and Regulations 483.45(c)(1-5)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48744 Based on observations, record reviews, and interviews during recertification survey, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs, which was any drug used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences which indicated the dose should be reduced or discontinued for 1 (Resident #78) of 4 resident reviewed for unnecessary medications. Specifically, Resident #78's physician order for Abilify (antipsychotic medication) did not include an indication for use in accordance with professional standards. This is evidenced by: Resident #78 was admitted to the facility with diagnoses of chronic systolic congestive heart failure, acquired deformity of right lower leg and major depressive disorder severe with psychotic symptoms. The Minimum Data Set (an assessment tool) dated 4/30/2024, documented the resident had minimal cognitive impairment, could be understood and could understand others. An undated facility policy titled, Mediation Regimen Review, documented a written diagnosis, indication, or documented objective findings was required for each medication order. Resident #78's physician orders dated 3/21/2024 documented the resident was to receive Aripiprazole 2 milligram tablet by mouth once daily. Additionally, the resident was to receive Aripiprazole 5 milligram tablet by mouth once daily. Neither order contained a reason for the medication order as required per regulation standards. Resident #78's progress notes reviewed for Medication Regimen Reviews, documented that the last 2 reviews were performed on 1/30/2024 and 10/23/2023. Upon request for Monthly Medication Regimen Reviews from Assistant Administrator #1, a Consultant Pharmacist Medication Regimen Review dated 3/17/2024 was provided as well as a Monthly Progress Note dated 2/22/2024 signed by Nurse Practitioner #1. Additionally, a Consultant Pharmacist Medication Regimen Review dated 2/26/2024 was provided as well as a Monthly Progress Notes dated 2/22/2024 signed by Nurse Practitioner #1. Documents did not contain a reason for the medication order. During an interview on 5/22/2024 at 1:50 PM, Director of Nursing #1 stated that the Medication Regimen Reviews were sent through email, and they received emails weekly. Director of Nursing #1 also stated that the reviews were put in the Medical Provider book if follow up was needed or to the unit manager. Additionally, the reviews were uploaded to the electronic record system used by the facility. Director of Nursing #1 stated that they believed the reviews should be done on admission, quarterly, or if there was a change in condition. The pharmacist came in 2-3 times a month and completed the review. During an interview on 5/22/2024 at 2:00 PM Registered Nurse #1 stated that medication regimen reviews were done on admission, when there were changes in medications or conditions, readmissions, or if something needs to be renewed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 2:06 PM Pharmacist #1 stated that they completed the Medication Regimen Reviews monthly and emailed them to the Director of Nursing when completed. 10 New York Code of Rules and Regulations 415.12(l)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation and interview during the recertification survey, the facility did not maintain drugs and biologicals, labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary standards, and expiration date when applicable for 3 of 3 units reviewed. Specifically: (1) urine was stored in the same refrigerator with multiple insulin pens and insulin vials; (2) purified protein derivative solution stored in the refrigerator with no open date was expired on , d+[DATE]; (3) eye drops, ear drops, Vitamin D, and insulin pens in the medication cart opened did not have expiration dates. Additionally, the controlled substance cabinet inside lock was broken. This is evidenced by: 48615 The facility's Medication Administration Policy and Procedure, effective ,d+[DATE] documented section 1. Controlled substances were obtained from the double-locked controlled substance cabinet. The facility's Pharmacy Services Policy and Procedure, effective 2022, documented drugs and biologicals used in the facility would be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility would provide separately locked, permanently affixed compartments for storage of controlled as required by prevailing regulation. Drugs and biologicals would be handled in a manner consistent with best practice for infection control at all times, including in storage and administration. The facility's Specimen Collection and Storage Policy and Procedure, effective 2023, documented lab specimens that required refrigeration or freezing were to be stored in the refrigerator that was labeled and intended for strictly this purpose; at no time were biological specimens to be co-mingled with food, medications or other items. During an observation on [DATE] 09:14 AM, South Unit Medication Cart #2 contained an opened bottles of Lumigan eye drops and Olopatadine Hydrochloride eye drops, both with no open and or expiration dates. An open bottle of Vitamin D with no open and or end-use expiration date. At the time of observation, Licensed Practical Nurse #2 stated when they opened stock medications, they labeled the bottle with open dates. Licensed Practical Nurse #2 stated there had been 8 Director of Nurses since they had been working on South Unit; there had been no clear directive for nursing staff and some things were not done. During an observation on [DATE] at 10:11 AM, the Medication Room on East Unit Side 2 Narcotic Box inside lock was broken. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of observation, Licensed Practical Nurse # 5 stated this was the first time they were made aware lock was broken and contacted maintenance. During an observation on [DATE] at 10:20 AM, the Medication Room on East Unit refrigerator contained a 24-hour urine specimen stored in same refrigerator with multiple insulin pens; insulin vials, glatiramer acetate; and a purified protein derivative diluted (PPD) solution with no open date and an expiration date of , d+[DATE]. At the time of observation when the surveyor asked about the urine specimen, Licensed Practical Nurse # 5 removed the urine specimen and stated the specimen should be stored on the North Unit specimen refrigerator located in the laboratory. Licensed Practical Nurse # 6 discarded the purified protein derivative solution. During an observation on [DATE] at 9:19 AM, North Unit Cart #1 contained Cipro ear drops opened on [DATE] with no expiration date. The following stock meds were open with no expiration date: Melatonin, famotidine; stool softener. During an observation on [DATE] at 09:27 AM, East Unit Cart #1 contained Chewing Gum with no resident name. Licensed Practical Nurse #4 stated they were holding gum for a resident. There were two Toujeo Insulin Pens opened [DATE] with no expiration date. During an interview on [DATE] at 9:40 AM, Director of Nursing #1 stated laboratory specimens were to be kept in a separate refrigerator on North Unit. Medications were to be labeled according to manufacturer instructions. During an interview on [DATE] at 9:15 AM, Nurse Educator #1 stated they were in process of creating and implementing nurse competencies that included medication administration and skills. Currently nursing staff, were observed during their initial medication pass after hire. When nursing staff were required to complete a skill, they could ask Nurse Educator, Director of Nursing or another nurse if needed. Nurse Educator #1 stated lab specimens were kept in the medication room refrigerator along with medications. 10 New York Codes, Rules and Regulations 415.18(d)

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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 and staff interview during the recertification survey from 05/13/2024 to 05/23/2024, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the main kitchen and one (1) of 3 kitchenettes. Specifically, dented cans were with the common stock, the food temperature thermometer was out of calibration, and kitchen and kitchenette equipment were not clean and/or in good repair. This is evidenced by: During observations in the main kitchen and unit kitchenettes on 05/13/2024 from 11:05 AM through 12:02 PM: One #10-sized can mashed potatoes found in the common stock had a V-shaped dent in top seam of the can. Two #10-sized cans of red pepper strips found in the common stock had metal touching metal at top seam of the can. The slicer, stainless steel utility cart, handwashing sink, and floor under cooking equipment line were soiled with food particles and/or dirt. The food temperature thermometer was found not in calibration when tested in a standard ice-bath method as follows: 25 Fahrenheit. In the South Unit kitchenette, the refrigerator door gasket was split and uncleanable, and the drawers and cabinets were soiled with food particles. During an interview on 05/13/2024 at 11:25 AM, Food Service Director #1 stated that the dented cans found should have been in the dented can area, and the dietary aides that stock the shelves needed to be educated on dented cans. Food Service Director #1 stated that the slicer, stainless steel utility cart, handwashing sink, and floor under cook equipment line would be cleaned. During an interview on 05/20/2024 at 10:45 AM, Assistant Administrator #1 stated that kitchen staff would be educated on dented cans, and Food Service Director #1 would be directed to educate staff on the cleaning items found and proper thermometer calibration. Assistant Administrator #1 stated that Director of Maintenance #1 would be asked to replace the gasket on the South Unit refrigerator door, and Director of Housekeeping #1 will be asked to ensure the housekeeping staff cleaned the South Unit cabinets. 10 New York Codes, Rules and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14

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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 during the recertification survey, the facility did not dispose of garbage and refuse properly. Specifically, one (1) of 3 dumpsters was leaking waste and the dumpster area was not clean. This is evidenced by:. During observations on 05/13/2024 at 11:56 AM, the front dumpster was leaking a black oily liquid from the bottom, and a build-up of brown leaves was found on the ground around the back dumpster. During an interview on 05/14/2024 at 2:01 PM, Corporate Director of Maintenance #1 stated that the leaking dumpster would be replaced. During an interview on 05/20/2024 at 10:55 AM, Assistant Administrator #1 stated that the leaky dumpster had been replaced, and the area around the dumpsters would be cleaned that day. 10 New York Codes, Rules and Regulations 415.14(h)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, interview and record review conducted during a recertification survey, it was determined that the governing body did not implement policies regarding the management and operation of the facility. Specifically, the facility did not ensure professional staff were licensed, certified, or registered in accordance with applicable Federal and State laws for a full-time, onsite Administrator. The facility did not appoint a licensed and currently registered Nursing Home Administrator to provide onsite, full time oversight prior to expiration of New York State Department of Health Unlicensed Acting Administrator approvals. Additionally during the recertification survey, there was no Nursing Home Administrator onsite. This is evidenced by: Record review of New York State Department of Health 'notification and request for approval of unlicensed acting administrator' forms revealed the following: Facility Operator signed a request on 5/04/2023, submitted to the New York State Department of Health for Assistant Administrator #1 to act as unlicensed administrator for a period of 3 months beginning 5/04/2023, with Administrator #2 as the Administrator of Record. Facility Operator signed a request on 8/18/2023, submitted to the New York State Department of Health for Assistant Administrator #1 to act as unlicensed administrator for a period of 3 months beginning 5/04/2023, with Administrator #1 as the Administrator of Record. Form 'reason for request' documented 'extension request for supervision period of unlicensed acting administrator (Assistant Administrator #1) with aggressive recruitment efforts have not yet resulted in successful engagement of permanent licensed nursing home administrator.' Supporting documentation provided by the facility in the application read in part, 'supervising Licensed Nursing Home Administrator to provide minimum of 4-6 hours of on-site supervision per week, with routine telephone and/or email contact.' Facility Operator signed a request on 12/05/2023, submitted by Regional Nursing Coordinator #1, to the New York State Department of Health for Assistant Administrator #1 to act as unlicensed administrator for a period of 3 months beginning 12/05/2023. The request was approved by the New York State Department of Health on 12/06/2023 with an expiration of 3/05/2024. During general observations throughout the entire recertification survey, the Nursing Home Administrator (Administrator #1) was not noted to be in the building. All Administrator level questions were directed to Assistant Administrator #1. The office that staff directed surveyors to the 'Administrator' was Assistant Administrator #1's office. Record review revealed Assistant Administrator #1 was not a licensed nursing home administrator. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility document titled [NAME] Hills Nursing and Rehabilitation Center Facility Survey Report provided 5/17/2024, documented that the Nursing Home Administrator License expiration date was 12/31/2025. The facility's report further documented that Assistant Administrator #1 was the assistant and not the actual Administrator. During an interview on 5/22/2024 at 10:30 AM, Licensed Practical Nurse #2 stated that due to several changes in leadership many things had been missed. There have been about 8 Directors of Nursing over the last 8 years and 3 administrators. Assistant Administrator #1 was noted to be the acting administrator, but Licensed Practical Nurse #2 could not remember who was overseeing Assistant Administrator #1. In an email from Assistant Administrator #1 to the New York State Department of Health on 5/23/2024, Assistant Administrator #1 referred to themselves in their email signature line as 'Acting Administrator/Social Work Resource Liaison.' During an interview on 5/23/2024 at 1:09 PM, Assistant Administrator #1 stated that Administrator #1 was present in the building usually once a week for 4 to 6 hours. Assistant Administrator #1 further stated that Administrator #1 could be here [at the facility] more often if it were needed. When asked what Administrator #1 did when they were in the building, Assistant Administrator #1 stated that Administrator #1 guided them in the mechanics of their job. 10 New York Codes, Rules and Regulations 415.26

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48744 Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (NY00317289, NY00325414, NY00334048, NY00335064, NY00336444, and NY00336400), the facility did not ensure a quality assessment and assurance committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Additionally, the facility did not develop written policies and procedures for feedback, data collection systems, and monitoring, including adverse event monitoring. Specifically, the facility had repeat deficiencies in the areas of safe/clean/comfortable/homelike environment (F-584), food procurement, store/prepare/serve-sanity (F-812), and infection control (F-880); the facility did not ensure that previously approved Plans of Correction for F-584, F-812, and F-880 cited during Recertification Surveys completed on 5/10/2023, 4/14/2021, and 4/05/2019 were implemented as indicated by the same deficiencies being issued on the current survey. This is evidenced by: The facility policy titled, Quality Assurance Performance Improvement with effective date 2022, documented the purpose was to evaluate their residents experience of the services that were provided to determine how the experience could be improved, to realize the facility's vision of innovation and continuous improvement in the delivery of care. It also documented the committee was to evaluate the quality of care provided to our residents and hold ourselves to the highest standard by continually improving the care of the resident's behalf. There was no documented evidence of written procedures for developing, monitoring and evaluating performance indicators, including the frequency and how the facility would develop, monitor, and evaluate its performance indicators. There was no documented evidence of written procedures for how the facility would develop corrective actions designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems. There was no documented evidence of written procedures for how feedback would be obtained, what to collect and how to use the data collection to inform monitoring. There was no documented evidence of written procedures for what data would be collected from an adverse event for the purposes of monitoring, or what instances would be considered adverse events. Record review of previous Recertification Survey Statement of Deficiencies issued by the New York State Department of Health revealed the facility received deficient practice statements for F Tags F-584 (provide a clean, comfortable, homelike environment), F-812 (ensure food was prepared, stored and served in accordance with professional standards for food safety), and F-880 (maintain an infection control program). (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/23/2024 at 1:09 PM, Assistant Administrator #1 stated that the facility used the Quality Assurance Performance Improvement plan as the process to evaluate each department for deficits and to monitor adverse events. Information discussed included what departments found lacking was derived from past surveys, by grievances filed, or issues identified by staff. When a problem was identified, the committee looked at the data gathered related to the issue and implemented programs that led to improvement. Assistant Administrator #1 stated that the department heads met daily to discuss important issues and subcommittees were created to help implement improvements made. Additionally, there was a tracking sheet that was given to all the department heads to fill out. The trackers were reviewed in the daily meeting and in the Quality Assurance meeting. The documents were then audited to ensure areas of concern were effectively addressed. Assistant Administrator #1 stated that a town hall meeting as well as the Quality Assurance meeting were held monthly to ensure resident concerns as well as staff concerns could be addressed. 10 New York Codes, Rules and Regulations 415.27(a-c)

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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. 48744 Based on observation, record review, and staff interviews during the recertification survey, the facility did not ensure infection control practices in accordance with professional standards of care for 1 (Resident #24) of 1 resident reviewed. Specifically, Resident #24 peripheral inserted central catheter dressing changes were not done per physician orders to prevent infection. This is evidenced by: 48615 The Facility's Peripheral Inserted Central Catheter Insertion and care Policy and Procedure effective 1/17/2019, documented general guidelines to include: 1. Dressings must stay clean, dry, and intact. 2. Change transparent semi-permeable membrane dressings at least every 5-7 days and as needed (when wet, soiled, or not intact). The following information should be recorded in the resident's medical record: 1. Date and time dressing was changed. 2. Location and objective description of insertion site. 3. Any complications /interventions that were done. 4. Condition of sutures (if present). 5. Any questions, education given to resident, resident's statement regarding intravenous therapy and response to procedure. 6. Signature and title of the person recording the date. According to the Centers for Disease Control and Prevention's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, last reviewed 11/19/2022, retrieved 4/23/2024 online from https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html, core infection control practices in a healthcare should include training and education of healthcare personnel on infection prevention practices as well as monitoring and feedback. Core practices should include development of processes to ensure that all healthcare personnel understood and were competent to adhere to infection prevention requirements as they performed their roles and responsibilities and provided written infection prevention policies and procedures that were available, current, and based on evidence-based guidelines. Resident #24 was admitted with diagnoses of osteomyelitis (infection that has spread to the bone) of vertebra (spine) sacral and sacrococcygeal region (low back and tailbone); obstructive and reflux uropathy; (back-up of urine into the kidneys); systemic lupus erythematosus (the immune system of the body mistakenly attacks healthy tissue, mainly skin, blood, and joints). The Minimum Data Set (an assessment tool) dated 5/12/2024, documented resident had moderate cognitive impairment, could be understood and understand others. Resident #24's right upper arm had a Peripherally inserted central catheter (a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the right side of the heart called the superior vena cava) dressing. The Medication Administration Record dated May 2024 documented change dressing every Wednesday and as needed. Registered Nurse #1 signed Medication Administration Record on 5/15/2024 that indicated Peripherally inserted central catheter dressing was changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/16/2024 at 2:13 PM, the right upper arm Peripherally inserted central catheter dressing for Resident #24 was peeling away from skin; edges of dressing were curled with soil along edges; dressing was not dated; double lumen lines were dangling and tucked behind resident. During an observation on 5/17/2024 at 9:53 AM, Peripherally inserted central catheter dressing for Resident # 24 was clean, dry and intact. Dressing was dated for Thursday, 5/16/2024 at 9:00 PM. The double lumen ports were dangling behind Resident #24, white port had no cap covering insertion site. The surveyor informed Registered Nurse #1 of the observation, and Registered Nurse #1 immediately placed cap onto exposed port. During an interview on 5/16/2024 at 2:30 PM, Director of Nursing #1 verbalized policy and procedure steps to change central line dressings. They stated the order was to change dressing weekly should be dated and signed. The Director of Nursing #1 stated, Registered Nurse #1 was a former emergency room Nurse and knew how to change central line dressings. They also stated Peripherally inserted central catheter lines were to be flushed weekly and the order to flush daily should have been discontinued. 10 New York Codes, Rules and Regulations 415.19(b)(4)