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	07/30/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer medication when clinically appropriate for three (3) (Residents #'s 10, 29, and 47) of three (3) residents reviewed for self-administration of medication. Specifically, (a.) Resident #'s 10 and 29 were observed with unprescribed medications on their nightstands; and (b.) Resident #47 was noted to have discontinued Clindamycin Phosphate cream in their nightstand. There was no documented evidence that Resident #'s 10, 29, and 47 were assessed by an interdisciplinary team to determine their ability to safely self-administer medications, and there was no physician order for self-administration of medications.This is evidenced by:The Facility Policy titled, Resident Self-Administration of Medication, created 7/2020, documented that residents who expressed a wish to self-administer medications would be assessed by nursing and by rehabilitation services for their ability to do so safely. This assessment would include parameters of cognitive ability, awareness of dosing times, understanding of purpose for medication and awareness of potential outcomes if not completed, manual dexterity, ability to understand and observe any applicable infection control practices, ability to maintain storage safely and securely and ability to report to nursing when re-supply was needed. The physician would issue the appropriate medical order for residents who met the criteria for self-administration. Residents who were not fully able to meet all of the above criteria but were cognitively eligible would be facilitated in self-administration of medications with the appropriate level of staff support.Resident #10Resident #10 was admitted to the facility with diagnoses of multiple sclerosis (a chronic, often debilitating disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and tachycardia (a condition where the heart beats faster than normal, typically more than 100 beats per minute). The Minimum Data Set (an assessment tool) dated 7/22/2025, documented the resident was understood, able to understand others, and was cognitively intact.During an observation and interview on 7/21/2025 10:58 AM, Resident #10 was lying in bed. An unopened box of Nasacort Allergy 24 Hour Spray was noted on their nightstand. There was no name on the box. Resident #10 stated they were unsure where the nasal spray came from, but it had been there for a while.During an observation on 7/28/2025 at 11:48 AM, the unopened box of Nasacort nasal spray was noted on Resident #10's nightstand.A review of Resident #10's medical record did not include documented evidence that the resident was assessed for their ability to self-administer their medications. A review of Resident #10's Comprehensive Care Plan did not include documented evidence that the resident could self-administer their medications.A review of the physician orders for Resident #10 dated 4/21/2025, documented Fluticasone Propionate 50 microgram/actuation nasal spray, suspension. 2 sprays (100 micrograms) to be inhaled by nasal route once daily at bedtime for other seasonal allergic rhinitis.A review of the physician orders for Resident #10 did not include an order for the use of Nasacort Allergy 24 Hour Spray. During an interview on 7/25/2025 at 11:39AM, Licensed Practical Nurse #1 stated family must have brought in the nasal spray found on Resident #10's nightstand.Resident #29Resident #29 was admitted to the facility with diagnoses of type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), chronic obstructive pulmonary disease, and acute on chronic diastolic (congestive) heart failure (a sudden worsening of symptoms of a pre-existing condition of weakened heart muscles). The Minimum Data Set, dated [DATE], documented the resident could be understood, understand others, and had moderate cognitive impairment.During an observation and interview on 7/21/2025 at 11:48 AM, Resident #29 was lying in bed. There was a bottle of Hydrocortisone cream on their nightstand with no name, dated 5/11/2025. Resident #29 stated the cream was used for a rash that developed under their breasts and in their folds at times. They stated they did not put the cream on by themselves.During an observation on 7/22/2025 at 9:38 AM, the same bottle of hydrocortisone cream was on Resident #29's nightstand.A review of Resident #29's medical record did not include documented evidence that the resident was assessed by an interdisciplinary team for their ability to self-administer their medications. A review of Resident #29's Comprehensive Care Plan did not include documented evidence that the resident could self-administer their medications.A review of the physician orders for Resident #29 did not include an order for the use of Hydrocortisone cream.During an interview on 7/25/2025 at 11:39 AM, Licensed Practical Nurse #1 stated Resident #29's family must have

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observations, record reviews, and interviews conducted during the recertification survey, the facility did not ensure that residents had the right to be treated with respect and dignity to retain and use personal possession, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents for one (1) (Resident #14) of five (5) residents reviewed for personal property. Specifically, (a.) for Resident #14 was observed at nurses' station, in a common area, wearing a hospital gown. Resident #14 stated they were wearing a hospital gown because their clothing was not returned to them from the off-site laundry facility. This is evidenced by: The Facility's Policy titled; Resident Rights last reviewed 7/2022 documented resident have the right to keep and use their personal belongings and property as long as they did not interfere with the rights, health, or safety of others. Resident #14 was admitted to the facility with diagnosis of Parkinson's Disease (a progressive neurological disorder that primarily affects movement, but can also impact mental health, sleep, and pain), major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities. and Schizophrenia unspecified (a chronic mental health condition characterized by disruptions in thought processes, perceptions, emotions, and behavior). The Minimum Data Set (an assessment tool) dated 5/04/2025 documented the resident was severely cognitively impaired, usually could be understood, and understand others.During an observation on 7/21/2025 at 11:45 AM and 7/23/2025 at 12:30 PM, Resident #14 was observed sitting in wheelchair at nurses' station along with other residents in the common area, wearing a hospital gown, untied in back. During an interview on 7/21/2025 at 11:45 AM, Resident #14 stated they were wearing a hospital gown because they had no clothing. Their clothing had not been returned from laundry, which happens all the time. During an interview on 7/21/2025 at 1:30 PM, Regional Social Worker #1 stated missing laundry was reported. Laundry was sent to an outside service; it was sent out in a bag labeled patient room and returned clean in same bag. There were times articles of clothing or other laundry was missed and later relocated. If not found, facility would replace items, if the resident filed a grievance.During an interview on 7/30/2025 at 9:55 AM, Regional Administrator #1 stated they were aware of missing laundry items. The facility used an outside service for laundry. The process was each resident had a mesh bag. Once mesh bag was full, it goes into a bundle then to the laundry service. The laundry was returned in the same bag once cleaned, which was usually on the next delivery day. Regional Administrator #1 stated they would investigate why laundry was not returned timely. 10 New York Code of Rules and Regulations

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, record review, and interviews conducted during recertification surveys, the facility did not ensure action as a fiduciary (trustee) of the resident's funds and hold, safeguard, manage, and account for the residents' personal funds deposited with the facility. Specifically, seven (7) out of eight (8) residents at a surveyor led Resident Council meeting reported they were not able to get money from their resident funds account because the money in the cash box at the reception desk would be empty, even if the arrangements for withdrawal were made in advance.This is evidenced by:The Facility's Policy titled, Resident Finance dated 9/2024, documented the facility would maintain written records of all financial arrangements with the resident or responsible family member and/or source of payment; copies of monthly statements would be provided to the resident, family, and/or source of payment on request. The facility would provide to the residents the service of holding monies in trust. The facility would maintain an individual resident Personal Income Account ledger recording the deposit and withdrawal of funds which would be available to residents or legal representative at the Reception Desk in the Lobby, seven days a week, 24 hours a day. Written receipts would be given for all personal possessions and funds received or deposited with this facility. Petty cash was only disbursed on the resident's signatures or Power of Attorney. However, if the medical records indicated that the resident was unable to sign, the Nurse or the Social Worker would sign for the resident.The Facility's Policy titled, Resident Personal Income Account, dated 9/2024, documented all Personal Income Account funds were deposited directly into a resident account at a facility designated bank and designated Personal Income Account. A cash reserve would be kept in the Petty Cash fund. Records of the individual resident's account would be maintained. Deposits and withdrawals could be made at the Reception Desk in the Lobby, seven days a week, 24 hours a day.During the surveyor led Resident Council meeting on 7/23/2025 at 9:38 AM, residents stated they had to make arrangements in advance to get their money and frequently when they went to get the money, they were told there was none. The vending machines cost money so the residents could not use the vending machines because they could not get money.During an interview on 7/25/2025 at 10:00 AM, Administrator #1 stated personal funds from corporate were kept in a box at the reception desk. Corporate brings money once a week, which was usually $500 to $600 dollars in $5s and $1s. Sometimes the delivery came every other week. If the box ran out of money and a resident wanted money before the delivery came, Administrator #1 stated that they gave the residents a few bucks because they usually only wanted to use the vending machine. They stated there was an accounting sheet they used to track resident funds. Administrator #1 stated relative of the owner managed accounts off site and their contact information was provided.During an interview on 7/25/2025 at 12:48 PM, Receptionist #1 stated that residents needed to sign out their money. They stated they kept a list of trial balances and the sign out sheet was sent to Corporate Personal Funds Manager #1. Receptionist #1 stated that when they run out of room on the balance sheets, they had to call and ask for a new sheet. Copies of the current sheet at the time of the interview was provided. The sheets provided listed the resident name, their current balance, the resident's monthly allowance amounts, and the resident's account status. The sheets provided had handwritten dates and amounts written under account status and the balances were crossed out and new balance amounts handwritten in next to them (and around them as space allowed) which indicated what the new balances were after withdrawals were made. Receptionist #1 verified the handwritten alterations were written by them at the time of the resident's withdrawal. Receptionist #1 stated that a corporate person came with envelope full of cash, but there was no set time as to when they were coming. The cash envelope got handed to Administrator #1, who gave it to Receptionist #1 who kept it in the locked box. The cash box, drawer the box was kept in and the door to the reception office were all separately locked. During the interview, Receptionist #1 opened the drawer without unlocking it and the lock box was wide open. Receptionist #1 stated that they thought they had the only key to the box. The drawer and door may have had other keys, but they could not say for sure. Receptionist #1 stated that maybe the supervisor had keys. The lock box shown during the interview had about $80 in $20 bills from making change for people, about $100 in $1 dollar bills and $50 in $5 dollar bills. It was noted that these amounts were not exact counts, just quickly calculated based on what Receptionist #1 stated and thumbed through. Receptionist #1 stated that the cash usually lasted about two weeks. If they ran out, it usually took a day or two for the envelope of money to be delivered.During an interview on 7/28/2025 at 10:52 AM, Corporate Personal Funds Manager #1 stated that Receptionist #1 kept the resident funds. The tally list got sent from Receptionist #1 weekly so

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on record review and interviews conducted during the Recertification survey, the facility did not ensure that residents had the right to send and promptly receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service. Specifically, residents did not receive mail on Saturdays. This impacted all residents within the facility.This is evidenced by: Facility Policy titled, Resident Right-Right to Forms of Communication with Privacy, dated 11/2024, documented residents had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the residents through a means other than the postal service. During a surveyor led Resident Council Meeting on 7/22/2025 at 10:32 AM, eight (8) of eight (8) residents present reported mail was not delivered to them on Saturdays. During an interview on 7/25/2025 at 10:45 AM, Director of Activities #1 stated mail was delivered to the front desk after lunch time Monday through Friday. A staff member from the activities department sorted the mail according to unit and the mail was then delivered to the unit to be distributed to the residents. Mail was delivered to the residents Monday through Friday. Mail was not delivered to the Residents on Saturdays because there was no one there from the activities department to receive and distribute the mail. During an interview on 7/25/2025 at 10:56 AM, Administrator #1 stated delivery of mail to the residents was completed by the Activities department. They stated they did not know when letters were delivered to the residents and stated they would need to check with Director of Activities #1 regarding when letters were delivered. 10 New York Code Rules and Regulations 415.3(e)(2)(i)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. This is evidenced by:The Facility Policy titled, Resident Right- Right to Survey Results/Advocate Agency Information, last reviewed 11/2024, documented it was the policy of the facility to inform residents of survey results and advocate agencies in such manner to acknowledge and respect resident rights. The facility will post in a place readily accessible to residents, family members, and legal representatives of residents the results of the most recent survey of the facility. The facility will post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.During a surveyor led Resident Council Meeting on 7/22/2025 at 10:32 AM, eight (8) of eight (8) anonymous residents present stated they did not know where survey results were located for them to read.During a walkthrough of the facility on 7/22/2025 at 11:50 AM, a white binder with survey results was observed on the second shelf of a shelving unit in the lobby. There was a sign listing visiting hours taped to the shelf above the binder. The sign hung down directly in front of the binder, obstructing it from view. There were no signs in the lobby that indicated survey results were available to view. There were no survey binders or signs stating the results of surveys were available for viewing on East, North, and South units or in hallways that connected the units. During an interview on 7/25/2025 at 10:56 AM, Administrator#1 stated results of most recent surveys were kept in a binder in their office, and there was also a copy kept in a binder in the shelving unit in the lobby. They stated there were no signs posted that listed where the results of the surveys were located for residents or visitors to view.During an observation on 7/29/2025 at 9:54 AM, the binder that contained the survey results was not on the shelving unit in the lobby where it was previously kept. It was not located anywhere in the lobby.During an interview at this time, Receptionist #1 stated there were always a binder that contained survey results in the shelving unit, but that it was not there now. They stated they would have to ask Administrator #1 where it was.During an interview at this time, Corporate Administrator #1 stated the binder was in the office of Administrator #1 and they went to retrieve it.During an interview on 7/29/2025 at 11:34 AM, Director of Nursing #1 stated survey results were to be kept in a binder in the front of the building so any resident or visitor could access them. They stated they did not know if there was a sign posted noting the availability of survey results but should be. 10 New York Code Rules Regulations 415.3 (d)(1)(v)

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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. Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure residents were aware of the grievance process. Specifically, (1.) residents on South Unit did not have the option to file a grievance anonymously; and (2.) seven (7) out of eight (8) residents at a surveyor led Resident Council meeting reported they did not know the process by which to file a grievance.This is evidenced by:Facility Policy titled, Grievance Reporting and Response, last revised 7/01/2022 documented it was the policy of the facility to investigate and respond to all resident grievances in a timely manner. The procedure to file a grievance included filling out a grievance form and giving it to the Director of Social Services or put it in the grievance box located by the social work office. Grievances could also be filed verbally with the Director of Social Services or Administrator. Grievances may be named or anonymous when put in the drop box.During a surveyor led Resident Council meeting on 7/22/2025 at 10:32 AM, seven out of eight residents present stated they were unsure how to file a grievance within the facility. The residents stated they could take their complaint to the resident council president, and the resident council president could follow up with whom they needed to follow up with. All eight residents present during this meeting were unaware of who the grievance official was in the facility. During an observation on 7/22/2025 at 11:50 AM, a suggestion/grievance box in which grievance forms could be deposited anonymously were seen on North Unit and East Unit on the wall across from the nurse's station. There was no suggestion/grievance box for depositing anonymous grievances on the South Unit. There was no suggestion/grievance box by the social work office as noted in the facility policy. There were no other suggestion/grievance boxes in common areas such as the lobby, by the dining room, or by the therapy gym.During an interview on 7/25/2025 at 9:56 AM, Director of Social Services #1 stated they were the grievance official in the facility. They stated there was a sign posted on the bulletin board of each unit with their email address and phone number that stated they were the grievance official. They stated they verbally notified residents they were the grievance official upon admission to the facility, but it was not noted in the admission paperwork provided to the resident that they were the grievance official. They stated a resident on the South Unit tried to rip the suggestion/grievance box f of the wall, so it was removed and there were no suggestion/grievance boxes in common areas or outside of the social services office for them to file a grievance anonymously.During an interview on 7/25/2025 at 10:56 AM, Administrator#1 stated grievances went to the social services department, but they try to keep all residents happy. When asked if all residents could file a grievance anonymously, they stated the residents could call the Department of Health anonymously to file a grievance or the resident could fill out a grievance form and not sign it. Administrator #1 stated they were not aware where the suggestion/grievance boxes were off the top of their head, but they thought they were located on the units.During an interview on 7/29/2025 at 11:34 AM, Director of Nursing #1 stated all grievances went through the social services department and they were discussed during morning report. If a resident wanted to file a grievance anonymously, there were supposed to be boxes on all the units for them to do so, and they assumed there were boxes on all the units. 10 New York Codes Rules and Regulations 415.3(c)(1)(i)

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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 Based on record review and interviews during the recertification survey, the facility did not ensure a base line care plan was developed and implemented for each resident within 48 hours of admission for one (10 (Resident #114) of 30 residents reviewed for baseline care plans. Specifically, for Resident # 114, a baseline care plan was not developed within 48 hours of admission.This is evidenced by:Resident #114 was admitted to the facility with the diagnoses of vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and metabolic encephalopathy (a condition where brain function is disrupted due to chemical imbalances in the body, often resulting from illnesses or organ dysfunction). The Minimum Data Set (an assessment tool) dated 7/23/2025 documented the resident was usually able to be understood, was usually able to understand others, and was severely cognitively impaired.The Policy and Procedure titled, Comprehensive Care Plans, last revised 5/2024, documented every resident would have an interdisciplinary care plan with the interim/baseline interdisciplinary care plan initiated within 48 hours of admission.A review of Resident #114's medical record did not have documented evidence of baseline care plan.In an email received 7/25/2025 at 10:53 AM, Regional Nursing Coordinator #1 stated they could not locate a baseline care plan for Resident #114.During an interview on 7/28/2025 at 12:10 PM, Director of Nursing #1 stated that a baseline care plan should be put in place for every resident when they are admitted . They were unable to explain why Resident #114 did not have a baseline care plan. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This is evidenced by:The policy and procedure titled, Comprehensive Care Plans, last revised 5/2024, documented interdisciplinary comprehensive care plans would identify problems and needs, reflecting the resident's strengths, limitations, and goals.Resident #2Resident #2 was admitted to the facility with the diagnoses of dementia, major depressive disorder, and atrial fibrillation (irregular heartbeat). The Minimum Data Set (an assessment tool) dated 7/02/2025, documented the resident was able to understand others, be understood, and was severely cognitively impaired.During a general observation of the unit on 7/21/2025 at 10:52 AM, Resident #2 was still in bed, still sleeping, and did not appear to have been gotten up or cleaned up for the day. The resident was noted to have floor mats next to their bed, call bell on the floor.Resident #2's Comprehensive Care Plan for Risk for Falls, dated 11/30/2024, documented to keep the resident's environment safe and clutter free, call bell within reach and encourage use. The care plan was revised 1/17/2025 to include a raised edge mattress.There was no documented evidence of the use of floor mats in any of Resident #2's comprehensive care plan care areas.There was no documented evidence of provider's order to use floor mats in Resident #2's room.Resident #16Resident #16 was admitted to the facility with the diagnoses malignant neoplasm of left kidney (cancerous tumor characterized by uncontrolled cell growth that can invade nearby tissues and spread to other parts of the body), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs). The Minimum Data Set, dated [DATE] documented the resident was understood, could understand others, and was cognitively intact. The Comprehensive Care Plan titled, Edema did not have documented evidence of goals or interventions. During an interview on 7/28/2025 at 12:10 PM, Director of Nursing #1 stated that comprehensive care plans should have goals and person-centered interventions addressing each area of care.Resident #77Resident #77 was admitted to the facility with inflammatory spondylopathies (a group of chronic inflammatory diseases that primarily affect the spine and other joints), chronic pain syndrome (persistent pain that lasts weeks to years), and cellulitis of the lower leg (a common bacterial skin infection that can cause redness, swelling, pain, and warmth in the affected area). The Minimum Data Set, dated [DATE] documented the resident was understood, could understand others, and was cognitively intact. The Minimum Data Set documented the presence of one venous or arterial ulcer.A Physician's Order dated 7/14/2025 documented to cleanse left lower extremity with wound cleanser, pat dry, apply xeroform to open areas (cut to size), urea cream to scabbed areas, cover with dry dressing and kerlix, then apply Coban dressing from toes to knee three times weekly on shower days.A Progress note dated 6/25/2025 documented the resident was seen on wound rounds, wound was measured, and resident would continue to be followed on wound rounds.A Progress Note dated 7/14/2025 documented the resident was seen on wound rounds with a treatment order change and would continue to be followed by wound care.Review of resident's medical record did not include documented evidence of a comprehensive care plan for wounds, open areas, or impaired skin integrity. During an interview on 7/28/2025 at 11:48 AM, Regional Nursing Coordinator #1 stated they would expect a care plan for any open area that was being tracked and treated.During an interview on 7/28/2025 at 12:37 PM, Director of Nursing #1 stated there should have been a care plan in place to address the wound. 10 New York Codes, Rules, and Regulations 415.11(c)(1)

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	335389	A. Building B. Wing	07/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conductedion during the recertification survey, the facility did not ensure the resident's comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment based on changing goals, preferences, and needs of the resident for two (2) (Resident #'s 16, and 47) of 30 residents reviewed. Specifically, (a.) for Resident #16, there was no documented evidence that the Comprehensive Care Plan for Psychotropic Drug Use was reviewed and revised after a psychotropic medication change occurred on 7/03/2025; and (b.) Resident #47's Comprehensive Care Plan for Physical Therapy was not reviewed and revised after each assessment or after they discharged from physical therapy services on 7/15/2025. This is evidenced by:The Facility Policy titled; Comprehensive Care Plans dated 4/2019 documented the care plan would be complete, current, realistic, time specific and appropriate to each resident's individual needs. A comprehensive care plan would be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Care Plans were modified between care plan conferences when appropriate to represent the resident's current needs, problems, and goals. The Care Plan would be updated and/or revised for the following reasons: (a.) significant change in the resident's condition; (b.) a change in planned interventions; (c.) goals were achieved and new goals established to meet the resident's current needs and/or goals; and (d.) when a resident received a new diagnosis, new medication, or had abnormal labs. Any revision, addition, or deletions to the care plan would be dated and initialed. Regularly scheduled resident care conferences were held by the 21st day after admission, quarterly, annually, or if a significant change in status occurred. Resident #16Resident #16 was admitted to the facility with diagnoses of type 2 diabetes (an endocrine system dysfunction when the body cannot use insulin correctly and sugar builds up in the blood), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and major depressive disorder (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life). The Minimum Data Set (an assessment tool) dated 7/06/2025, documented that the resident was cognitively intact, could be understood, and could understand others.A Comprehensive Care Plan titled, Psychiatric Drug Use initiated on 7/01/2025, documented Resident #16 was on Trazadone and Auvelity related to major depressive disorder.An order for Auvelity 45 milligram - 105 milligram tablet, extended release, give 1 tablet by oral route 2 times per day for major depressive disorder initiated on 7/01/2025 was discontinued on 7/03/2025.An order for Bupropion 150 milligrams tablet, 12 hour sustained release, give 1 tablet by oral route 2 times per day for major depressive disorder was initiated on 7/03/2025.A progress note written by Director of Nursing #1 dated 7/03/2025, documented Auvelity was out of stock per the pharmacy. The psychiatrist was notified and recommended Bupropion in its place. The Nurse Practitioner was made aware. There was no documented evidence that the Comprehensive Care Plan for Psychiatric Drug Use was revised after Resident #16's order for Auvelity was discontinued and replaced with Bupropion. Resident #47Resident #47 was admitted to the facility with diagnoses of fibromyalgia (a chronic condition that causes widespread musculoskeletal pain, fatigue, and sleep disturbance), type 2 diabetes, and morbid obesity (a severe form of obesity characterized by a Body Mass Index (BMI) of 40 or higher). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and understand others.A Comprehensive Care Plan titled; Physical Therapy was initiated for Resident #47 on 12/06/2025. There was no documented evidence that the care plan was reviewed and revised after the quarterly assessments on 4/15/2025 and 7/15/2025.A document titled, Physical Therapy Discharge summary, dated [DATE] documented that Resident #47 was discharged from physical therapy services on 7/15/2025 after they achieved their highest practical level.There was no documented evidence that Resident #47's Comprehensive Care Plan for Physical Therapy was reviewed or revised with updated goals, interventions, or functional status after they discharged from physical therapy services. During an interview on 7/29/2025 at 9:08 AM, Licensed Practical Nurse #3 stated the Director of Nursing was supposed to update care plans. They stated they were aware that care plans were not being updated.During an interview on 7/29/2025 at 9:19 AM, Licensed Practical Nurse #1 stated that Director of Nursing #1 was responsible for updating care plans. They stated they had no concerns with getting their care plans updated.During an interview on 7/30/2025 at 10:04 AM, Director of Nursing #1 stated they did most of the updates to care plans. They stated there were two (2) other Registered Nurses that also worked on care

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Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observations, record reviews, and interviews conducted during the recertification survey, the facility did not ensure that the residents received the necessary care and services to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (1) (Resident #37) of 30 residents reviewed. Specifically, for Resident #37, the resident's room was bare of home-like touches and furniture with no care-planned reason or physician order.This is evidenced by:Resident #37 was admitted to the facility with the diagnoses of type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), dementia (a group of thinking and social symptoms that interferes with daily functioning), and schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). The Minimum Data Set (an assessment tool) dated 5/08/2025 documented the resident was able to be understood, understand others, and was severely cognitively impaired.During an observation on 7/21/2025 at 11:37 AM, the resident's mattress was noted to be on the floor without a frame. The room was observed to be empty with no furniture (for example a dresser or nightstand) and the walls were bare. There were no homelike touches observed in Resident #37's room.The Progress Note dated 6/25/2025 documented the resident was found lying on the floor under the bed.The Physician's Orders were reviewed. There was no documented evidence of an order for the resident's room to be stripped bare and the mattress to be placed on the floor without a bedframe.The Comprehensive Care Plan was reviewed and there was no documented evidence of no care plan for no furniture, room decorations, or mattress on the floor. During an interview on 7/28/2025 at 12:10 PM, Director of Nursing #1 stated they had noticed the resident was not care planned for a mattress on the floor but they had corrected the care plan that morning.During an interview on 7/30/2025 at 9:28 AM, Certified Nurse Aide #7 stated they did not know why the resident's room was set up the way it was. They stated that the resident used to have a bed frame, but it was taken out.During an interview on 7/30/2025 at 9:34 AM, Licensed Practical Nurse #3 stated all furniture, and the bedframe had been removed from Resident #37's room because they would try to take apart the bed frame and behaviors made the resident unsafe. They stated that should be care planned for, but as a Licensed Practical Nurse, they did not deal with the care plans. They stated they were unsure if a physician order was required. 10 New York Codes, Rules, and Regulations 415.5

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification and abbreviated survey (Case #664249), the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming, personal and oral hygiene for six (6) (Resident #s 2, 47, 50, 71, 77, and 97) of ten (10) residents reviewed. Specifically, (a.) Resident #2 was observed to be unkempt and in need of assistance to perform activities of daily living; (b.) Resident #47 did not receive twice weekly showers as per the resident's plan of care; (c.) Resident #50 was observed on 7/22/2025 at 1:41 PM, 7/24/2025 at 1:10 PM, 7/28/2025 at 10:00 AM, and 7/29/2025 at 11:22 AM, in their room with door closed, temperature warm and sweltering, disheveled appearance, clothing soiled, unshaven, hair unkempt with strong urine odor; (d.) Resident #71 was not regularly offered or provided the opportunity to get of bed and was not given a bed bath or shower in accordance with their plan of care; (e.) Resident #77, the resident stated they were not being bathed; and (f.) Resident #97 reported that they were not regularly offered or provided the opportunity to shower, despite being care planned to receive showers twice a week because of a fungal infection.This is evidenced by:The facility's Policy and Procedure titled; Activities of Daily Living, dated 5/2024, documented the facility would ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. The facility would provide care and services for the following activities of daily living: (a.) Hygiene - bathing, dressing, grooming and oral care. (b) mobility - transfer and ambulation including walking (c) elimination - toileting (d) dining; eating, including meals and snacks; communication including speech, language and other functional communication systems. A resident who is unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.Resident #47 Resident #47 was admitted to the facility with diagnoses of fibromyalgia (a chronic condition that causes widespread musculoskeletal pain, fatigue, and sleep disturbance), type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or cannot properly use the insulin it produces, leading to high blood sugar levels), and morbid obesity (a severe form of obesity characterized by a Body Mass Index (BMI) of 40 or higher). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and understand others.The Comprehensive Care Plan dated 12/06/2024 titled; Activities of Daily Living documented that Resident #47 required extensive assist of 1 for bathing. Their shower days were Sunday and Thursday on the evening shift. Interventions included weekly shower per preferences/schedule and as needed. The Resident Certified Nurse Aide Documentation Record dated July 2025 for Resident #47 documented the resident's bathing schedule was Tuesday and Fridays on the morning shift.Review of Resident Certified Nurse Aide Documentation Record dated July 2025 for Resident #47, there was no documented evidence that resident received a shower on the following dates: 7/01/2025, 7/11/2025, 7/15/2025, 7/18/2025, and 7/28/2025. During an interview on 7/22/2025 at 12:38 PM, Resident #47 stated they were supposed to get a shower twice a week but were lucky if they got a shower once a week or even once every 3 weeks. They stated they were always told by staff that they were shorthanded. Resident #47 stated they needed to shower because they had skin breakdown. During an observation on 7/24/2025 at 2:25PM, Resident #47's hair was noted to be greasy and there was strong smell of urine present. During an interview on 7/24/2025 at 2:25PM, Resident #47 stated their showers were scheduled for Sunday and Thursdays on the evening shift. They stated they usually had to beg for a shower on the day it was scheduled and then they might get it.During an interview on 7/28/2025 at 12:42 PM, Director of Nursing #1 reviewed Resident #47's care plan and verified they should receive a shower on Monday and Thursday evenings. The care plan was correct, and the Certified Nurse Aide tasks were incorrect. They stated nursing had put the task in incorrectly and then updated the task. When asked if they were aware of any issues with residents not getting shower, Director of Nursing #1 stated a few residents had not gotten showers. They stated they had now informed staff that they needed to document better, like writing a note if a resident refused showers. They stated if there were staffing struggles, they would try to make up the shower if it was missed.Resident #71Resident #71 was admitted to the facility with diagnoses of morbid obesity (a severe form of obesity characterized by a Body Mass Index (BMI) of 40 or higher), major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life), and generalized anxiety disorder (mental health condition characterized by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being for three (3) (Resident #'s 34, 50, and 71) of four (4) residents reviewed. Specifically, Resident #'s 34, 50, and 71 did not consistently attend meaningful, accommodating activities to maintain their highest practicable quality of life. This is evidenced by:The Facility Policy titled; Activity Programs, last revised 5/2024, documented (a.) activity programs were designed to encourage maximum individual participation and were geared to the individual resident's needs; (b.) the activity programs consisted of individual, small, and large group activities that were designed to meet the needs and interests of each resident; (c.) individual and at least 4 group activities were offered per day; and (d.) individualized and group activities were provided that: reflect the schedules, choices and rights of the residents and reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of the residents. Resident #34Resident #34 was admitted to the facility with diagnoses of paraplegia (paralysis of the legs and lower body) without sensation below the waist, chronic osteomyelitis (a bone infection) of the pelvic bones, and neurogenic bladder (condition where the nerves that control the bladder function abnormally, leading to problems with urination). The Minimum Data Set (an assessment tool) dated 6/05/2025, documented the resident's cognition was intact, could be understood and understand others.A review of Resident #34's Comprehensive Care Plan did not include a plan titled or related to Activities. On 7/28/2025, during the recertification survey, the Comprehensive Care Plan was updated as follows: resident presents with an inability to participate in activities due to personal choice, physical limitations. Resident is invited to come to activities on a weekly basis but declines.During an observation on 7/22/2025 at 1:10 PM, Resident #34 was observed in bed wearing a hospital gown. They were watching television. A wheelchair was observed in the bathroom.During an interview at this time, Resident #34 stated they rarely got out of bed due to staffing shortages. They stated they were able to self-transfer from their bed to their wheelchair, but their wheelchair was in the bathroom. Resident #34 stated they would have to call for assistance to get the wheelchair and due to staffing shortages, they did not want to bother the staff. They stated they generally stayed in bed all day with the hope of discharging home. Resident #34 stated they did not really attend any activities.A review of the Activity Log dated July 2025 for Resident #34, documented a one-on-one (1:1) social visit on 7/05/2025. The remaining dates for the month of July 2025 were blank.Resident #50Resident #50 was admitted to the facility with diagnoses of multiple sclerosis (a chronic, often debilitating disease that affects the central nervous system, brain and spinal cord), dysphagia (difficulty or discomfort in swallowing), and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood and understand others.The Comprehensive Care Plan dated 6/23/2025 titled, Activities documented the resident did not participate in any activities offered due to personal choice. Resident will receive one-to-one (1:1) visits, sensory stimulation at least one (1) time per week to maintain communication.The Comprehensive Care Plan dated 1/17/2025, titled, Mood, documented problem as depressed; anxious. Interventions included to provide recreational activities; encourage participation in religious services.During observations on 7/22/2025 at 1:41 PM; 7/24/2025 at 1:10 PM, 7/28/2025 at 10:00 AM, and 7/29/2025 at 11:22 AM, Resident #50 was observed in their room, in bed, fully clothed, with the door closed. A review of the Activity Log dated July 2025 for Resident #50, documented a one-to-one (1:1) social visit on 7/06/2025. The remaining dates for the month of July were blank.During an interview on 7/24/2025 at 1:20 PM, Resident #50 stated they did not come out of room because ‘they, the people in charge,' would not let them out. Resident #50 was asked if they would like to attend an activity and they reiterated, the people in charge would not let them out. During an interview on 7/24/2025 1:30 PM, Director of Nursing #1 stated Resident #50 ambulated independently in and out of their room; and that Resident #50 chose not to attend activities. Resident #71Resident #71 was admitted to the facility with diagnoses of morbid obesity (a severe form of excess weight characterized by a Body Mass Index of 40 or higher), major depressive disorder (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life), and generalized anxiety disorder (mental health condition characterized by excessive fear

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents received treatment and care in accordance with professional standards for one (1) (Resident #16) of 30 residents reviewed. Specifically, for Resident #16, a large bruise was not reported and assessed in a timely manner.This is evidenced by:Resident #16 was admitted to the facility with the diagnoses malignant neoplasm of kidney (cancerous tumor characterized by uncontrolled cell growth that can invade nearby tissues and spread to other parts of the body), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs). The Minimum Data Set (an assessment tool) dated 7/06/2025 documented the resident was understood, could understand others, and was cognitively intact. During an observation on 7/29/2025 at 8:51 AM, Resident #16 was noted to have a large bruise on their left outer leg, from knee to midcalf.The Certified Nurse Aide Guide documented the resident required one-person physical help in part of bathing activity, one-person extensive assistance for dressing, and one-person extensive assistance with toilet use.The Physical Therapy Treatment Encounter Note dated 7/15/2025 documented Resident #16 reported pain in the left knee. They documented the resident had a bruise that was tender to the touch.The Progress Note dated 7/15/2025 documented the resident reported to staff that they fell. Medical provider was informed.The Accident and Incident Report dated 7/15/2025 documented the resident reported a fall on 7/08/2025 or 7/09/2025.The Treatment Administration Record for July 2025 did not have documented evidence of weekly skin checks completed on 7/01/2025 or 7/08/2025 as ordered.During an interview on 7/22/2025 at 11:37 AM, Resident #16 stated they had fallen while ambulating on 7/08/2025 or 7/09/2025 and unidentified staff assisted them.During an interview on 7/29/2025 at 10:34 AM, Licensed Practical Nurse stated that all ordered care should be provided for and documented as given.During an interview on 7/29/2025 at 12:05 PM, Director of Nursing #1 stated that skin checks should have been completed weekly and signed for. They stated that when the Certified Nurse Aide provided care and found a new bruise or other skin issue, it should have been reported immediately to the charge nurse.10 New York Codes, Rules, and Regulations 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one (1) (Resident #4) of two (2) residents reviewed for range of motion. Specifically, for Resident #4, a washcloth roll was not applied to the resident's left hand for contracture management as indicated by physician orders.This is evidenced by:The facility's Policy titled; Physical Rehabilitation Department Issuing and Use of Splints, undated, documented the Physical Rehabilitation Department staff were responsible for the evaluation and determination of appropriate splinting devices with assistance from Orthotist when necessary. The treating therapist assessed the resident's need for a positioning device for the involved extremity/body part and made recommendations for resident splinting needs (that is monitor for contracture, type of splint, indications and contraindications). If a splint was indicated, nursing staff was notified, and a specific wearing schedule would be documented in the resident's medical chart.The Facility's Policy titled; Comprehensive Care Plans, last revised 09/2023, documented the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Resident #4 was admitted to the facility with a diagnoses of hemiplegia (weakness or paralysis on one side of the body) following cerebral infarction (a condition where brain tissue dies due to lack of blood supply), type two (2) diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), and essential hypertension (high blood pressure with no identifiable underlying cause). The Minimum Data Set (an assessment tool) dated 7/07/2025 documented the resident had intact cognition, could be understood, and could understand others.Physician order dated 10/17/2024 documented for Resident #4, to apply daily towel rolls to left shoulder, elbow, and under forearm, apply washcloth roll to left hand as indicated in care plan for contracture management; apply at all times except care.Resident #4's Comprehensive Care Plan was reviewed. There was no documented evidence of contracture management care plan as mentioned in the physician's order.Contracture Joint Stiffness evaluation dated 6/10/2025 documented Resident #4 had a contracture in the left upper extremity. Regarding their wrist, flexion (the movement of bending the hand towards the forearm bringing the palm closer to the arm) was within functional limits, extension (when the wrist bends backwards with the back of the hand pulling away from the body) was negative 30 degrees, and phalanges (bones that make up the fingers) were flexed. Comments included Resident #4 had limited range of motion on left upper and lower extremity.During an observation on 7/22/2025 at 12:53 PM, Resident #4 was lying in bed. They stated their left hand was contracted. There was no washcloth roll in their left hand.During an interview at this time, Resident #4 stated no nursing staff attempted to put a washcloth roll in their hand today.During an observation on 7/28/2025 at 10:45 AM, Resident #4 was lying in bed. There was no washcloth roll in their left hand.Treatment Administration Record dated July 2025 documented left upper extremity (left upper arm including the shoulder, upper arm, forearm, wrist, and hand)- apply daily towel rolls to shoulder, elbow, and under forearm, apply wash cloth roll to left hand as indicated in care plan for contracture management. Apply at all times except care.Treatment Administration Record reviewed for the month of July through July 27, 2025 documented washcloth roll was applied and signed by nursing staff on 7/01/2025, 7/04/2025, 7/06/2025, 7/07/202025, 7/08/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, 7/15/2025, 7/16/2025, 7/18/2025, 7/20/2025, 7/21/2025, 7/22/2025, 7/23/2025, 7/24/2025/, and 7/27/2025 at 7:00 AM- 3:00PM, 3:00PM-11:00PM, and 11:00PM- 7:00AM. On 7/02/2025, it was applied and signed for by nursing staff on at 700AM-3:00PM and 11:00PM- 7:00AM. On 7/03/2025 it was applied and signed for by nursing staff at 7:00AM- 3:00PM and 3:00PM-11:00PM. On 7/09/2025 it was applied and signed for by nursing staff at 7:00 AM- 3:00PM and 11:00PM- 7:00AM. On 7/10/2025 it was applied and signed for by nursing staff at 7:00 AM- 3:00PM and 11:00PM- 7:00AM. On 7/19/25 it was applied and signed for by nursing at 7:00AM-3:00PM and 3:00PM-11:00PM. On 7/25/25 and on 7/26/2025 it was applied and signed for by nursing at 7:00AM-3:00PM and 11:00PM-7:00AM.Record review revealed no documented evidence that this treatment was done for the following dates/times: 7/02/2025 3:00 PM-11:00 PM, 7/03/2025 11:00 PM-7:00 AM, 7/05/2025 7:00 AM-3:00 PM, 3:00PM-11:00

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Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure that resident environments were as free from accidents hazards as is possible for one (1) (Resident #10) of nine (9) residents reviewed for accidents hazards. Specifically, Resident #10 resided in a semi-private room and two (2) disposable razors, and an unlabeled electric razor were observed in the resident's shared bathroom.This is evidenced by:Resident #10 was admitted to the facility with diagnoses of multiple sclerosis (a chronic, often debilitating disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and tachycardia (a condition where the heart beats faster than normal, typically more than 100 beats per minute). The Minimum Data Set (an assessment tool) dated 7/22/2025, documented the resident was understood, able to understand others, was cognitively intact, and required set up assistance for personal hygiene.Resident #10's roommate was admitted to the facility with diagnoses of Alzheimer's disease (is a type of dementia that affects memory, thinking and behavior), major depressive disorder (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life), and chronic obstructive pulmonary disease. The Minimum Data Set, dated [DATE], documented the resident was understood, could understand others, had severe cognitive impairment, and required supervision to touching assist with personal hygiene.During an observation on 7/21/2025 10:58 AM, two (2) disposable razors and an unlabeled electric razor were noted in a cabinet above the sink in Resident #10's bathroom. Resident #10 resided in a semi-private room and shared a bathroom with their roommate.During an observation on 7/29/2025 at 11:06 AM, two (2) disposable razors and an unlabeled electric razor were observed in Resident #10's bathroom. During an interview on 7/29/2025 at 11:10 AM, Licensed Practical Nurse #1 stated Resident #10 and their roommate should not have razors in their bathroom. Staff shave both Resident #10 and their roommate. When asked about the risks involved with this, Licensed Practical Nurse #1 stated the residents could use the razors to cut themselves and gestured to their wrist. Licensed Practical Nurse #1 stated they would remove the razors. During an interview on 7/29/2025 1:15PM PM, Director of Nursing #1 stated that resident's personal belongings should not be left in the bathroom unless they are in a private room for infection control reasons. They stated there are risks involved with razors being left in the bathroom. Director of Nursing #1 stated the facility had many residents that were ambulatory and/or [NAME] mental health issues. They stated a resident could get ahold of the razors and cut themselves or do something else that they should not. 10 New York Codes, Rules and Regulations 483.25(d)(1)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice, for one (1) (Resident #s 43) of two (2) residents reviewed for dialysis. Specifically, nursing did not consistently complete, reviewed, and logged dialysis communication sheets for Resident #43 between 4/08/2025 and 7/21/2025.This is evidenced by:The Facility's Policy and Procedure titled Care of Residents Receiving Hemodialysis, revised 9/2023, documented: Before Dialysis: Locate resident's dialysis Communication Book and enter pre-treatment information per the form fields. Include any relevant continuity of care information and vital signs. Ensure resident receives Activity of Daily Living and hygienic care well prior to departure time; ensure that resident takes Communication Book to treatment. Care After Dialysis: Obtain vital signs. If blood pressure drops more than 20 millimeters of mercury from the supine to upright position, the following interventions should be implemented: 1. Instruct resident to call for assistance when getting out of bed or up from the chair because of the potential loss of balance or dizziness. 2. Follow the fall prevention protocol carefully. 3. Notify physician if systolic blood pressure is less than 100 millimeters of mercury or much lower than the original baseline. Review Resident's Communication Book for entries made by the Dialysis Center and for any continuity of care information provided or requested for next visit. Record post-treatment data per the form fields. Enter resident's return in the clinical record as leave of absence return.Resident #43 was admitted to the facility with diagnoses of end stage renal disease (the final, irreversible stage of chronic kidney disease / when kidney are no longer able to function), essential hypertension (a condition characterized by persistently elevated blood pressure),and adjustment disorder (a mental health condition where a person experiences emotional or behavioral symptoms in response to a stressful event or change in their life). The Minimum Data Set (an assessment tool) dated 7/16/2025 documented resident had intact cognition, could be understood and understand others.The Comprehensive Care Plan titled, Renal Disease: Dialysis dated 4/14/2025 documented Resident is currently on dialysis Monday-Wednesday-Friday. Interventions: Follow dietary restrictions as per physician order. Monitor fluid intake and output, vital signs and weight as ordered by physician. Monitor for signs of infection and communicate with the dialysis center any abnormal findings non-crimping clamp at bedside for emergency use for bleeding from HD catheter. Provide renal diet as per physician order.During an observation on 7/22/2025 at 11:00AM, Resident #43's dialysis communication book could not be located. Registered Nurse #2 was asked to assist with locating the book and Registered Nurse #2y stated they were not sure where the book was at that time, perhaps it was left at dialysis.On 7/22/2025 at 11:50 AM, Resident #43's Dialysis Communication Log was reviewed; three dates were completed for 07/09/2025: 07/11/2025 and 07/14/2025. Electronic medical record had documentation of dialysis visits for 6/25/2025, 6/27/2025, and 6/29/2025.There was no documented evidenced of Dialysis Communication on 6/25/2025, 6/27/2025, and 6/29/2025.During an interview on 7/22/2025 at 11:36 AM, Director of Nursing #1 stated Resident #43's Dialysis Communication Book had been in the conference room for morning report. They stated Resident #43 had dialysis ordered for Monday, Wednesday and Friday at 11:00 AM. Director of Nursing #1 stated pre-dialysis vital signs taken and filed. Communication Book log was completed and sent to dialysis. Upon return the patient assessed, the Communication Book was reviewed, and a progress note was entered into the electronic medical record. Director of Nursing #1 stated resident had been at this facility for a few months and Registered Nurse #2 completed the Communication Book per policy. Director of Nursing #1 was made aware there were only documentation for 7/09/2025: 07/11/2025 and 07/14/2025 in Resident's Communication Book and electronic medical record had documentation of dialysis visits for 6/25/2025, 6/27/2025, and 6/29/2025. Director of Nursing #1 stated Dialysis Sheets were scanned then placed in the electronic medical record. They stated they will look into where the sheets were and if they were awaiting to be scanned.On 7/23/2025 at 2:55 PM, a document was sent via Health Commerce System requesting Resident #43's dialysis communication logs for 5/1/2025 - 7/23/2025. A second request was sent on 7/25/2025 at 11:02:15 AM. The documents were not received.During a subsequent interview on 7/28/2025 at 11:30 AM, Director of Nursing #1 stated dialysis documentation should be in in the electronic medical records. 10 New York Code of Rules and Regulations 415.12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observations, record review, and interviews conducted during the recertification and abbreviated survey (664249), the facility did not ensure provision of 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 throughout the facility. Specifically, the facility did not have the desired staffing levels for Licensed Practical Nurses and Certified Nurse Aides, and Registered Nurses as documented in the Facility Assessment for 13 of 13 days from 7/13/2025 to 7/25/2025. As a result of the insufficient staffing, nursing staff reported that indirect and direct resident care activities were unable to be completed. This included the inability to develop comprehensive care plans and the inability to supervise the implementation of resident-specific care plans. Additionally, multiple residents complained that they were not given care or had to wait excessively long times to get staff assistance.This is evidenced by:Cross Referenced: to F656: Comprehensive Care Plan, F657: Care Plan Timing and Revision, F677: Activities of Daily Living for Dependent Residents, F842: Resident RecordsThe facility census upon entry to the facility on 7/21/2025 was 110.The Facility Assessment last updated 2/26/2025, documented minimum staff required across 3 units. The Facility Assessment documented that the maximum capacity was 120 residents and that the average daily census was 92 percent occupation. The minimum staff documented as required to care for residents in a 24-hour period was 6-9 Licensed Practical Nurses, 9-27 Certified Nurse Aides, and 1 Registered Nurse (required for 8 hours), and that 3 Other nursing personnel e.g. those with administrative duties were required, with no documentation of the required time those 3 other nursing staff would be available.A review of Staffing Sheets dated 7/13/2025 to 7/25/2025 documented the following total staff numbers for a 24-hour period:7/13/2025 - 1 Registered Nurses, 11 Licensed Practical Nurses, 10 Certified Nurse Aides7/14/2025 - 3 Registered Nurses, 5 Licensed Practical Nurses, 10 Certified Nurse Aides7/15/2025 - 3 Registered Nurses, 6 Licensed Practical Nurses, 11 Certified Nurse Aides7/16/2025 - 3 Registered Nurses, 7 Licensed Practical Nurses, 10 Certified Nurse Aides7/17/2025 - 4 Registered Nurses, 4 Licensed Practical Nurses, 10 Certified Nurse Aides7/18/2025 - 3 Registered Nurses, 7 Licensed Practical Nurses, 6 Certified Nurse Aides7/19/2025 - 1 Registered Nurses, 4 Licensed Practical Nurses, 7 Certified Nurse Aides7/20/2025 - 1 Registered Nurses, 8 Licensed Practical Nurses, 7 Certified Nurse Aides7/21/2025 - 3 Registered Nurses, 6 Licensed Practical Nurses, 9 Certified Nurse Aides7/22/2025 - 3 Registered Nurses, 4 Licensed Practical Nurses, 10 Certified Nurse Aides7/23/2025 - 4 Registered Nurses, 6 Licensed Practical Nurses, 13 Certified Nurse Aides7/24/2025 - 4 Registered Nurses, 6 Licensed Practical Nurses, 12 Certified Nurse Aides7/25/2025 - 3 Registered Nurses, 2 Licensed Practical Nurses, 5 Certified Nurse AidesDuring general observations on 7/21/2025 at 11:40 AM, the North unit was noted to have one Licensed Practical Nurse and 2 Certified Nurse Aides on the unit.During general observations on 7/25/2025 at 8:19 AM, the North unit was noted to have one Licensed Practical Nurse and 2 Certified Nurse Aides.During general observations on 7/28/2025 at 9:08 AM, the South unit was noted to have one Licensed Practical Nurse and 2 Certified Nurse Aides.During an interview on 7/21/2025 at 11:54 AM, Resident #97 stated that they had been at the facility for 3 years. Resident #97 stated they did not have agency staff available. House staff were mandated to work frequently. Usually there was only one aide available on the unit. It was shocking that they had two (2) aides today. Sometimes there were no aides at night. Residents did not get to shower, and Resident #97 had not had a shower in two (2) weeks. It was normal for 1 aide on the floor and on the weekends, there were sometimes no nurses available.During an interview on 7/21/2025 at 12:33 PM, Resident #3 stated that the facility did not have enough staff to ask the resident what they needed. They had agency people there sometimes, but when there was one aide or one nurse on the floor, there was not anyone to provide the basic care to any resident. If there was one nurse aide, then it was unsafe. Sometimes there were no nurse on the floor. During an interview on 7/21/2025 at 2:21 PM, Resident #8 stated that there were very little staff, and they needed to wait long times for assistance. Resident #8 stated that there was only 1 aide all the time. During an interview on 7/22/2025 at 10:55 AM, Resident #9 stated that there was not enough staff. That day Resident #9 stated there was 1 unit manager who was passing meds and 2 Certified Nurse Aides. Resident #9 stated that they had not had no morning care as of 10:25 am and stated was sitting in their wet bed since last night.During an interview on 7/22/2025 at 11:31 AM, Resident #16 stated that they needed help to the bathroom and knew they did not have enough workers to answer lights quick enough. Resident #16 stated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews conducted 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 nursing staff did not have documentation of completed annual mandatory educations as listed in the Facility Assessment.This is evidenced by:The Facility assessment dated [DATE] documented Staff Training/Education and Competencies that were necessary to provide the level and types of care needed for the resident population: Resident's rights and facility responsibilities; Abuse, neglect and exploitation; Infection control; Culture change; In-service training for nurse aides no less than 12 hours per year, including dementia management training, and training for residents with cognitive impairments; Identification of resident changes in condition; and Cultural competencies.Additionally listed in the Facility Assessment were the Competencies, in parenthesis that it was not an inclusive list: Person-center care; Activities of daily living; Disaster planning and procedures; Infection control; Medication administration, Measurements; Resident assessment and examinations; Caring for persons with Alzheimer's or other dementia; Specialized care; Care for residents with mental and psychosocial disorders.Education records were provided for Licensed Practical Nurse #4, Licensed Practical Nurse #1, Licensed Practical Nurse #5, Certified Nurse Aide #4, Certified Nurse Aide #5, and Registered Nurse #1. All education records were noted to be incomplete for annual educations and varied in the number of educations provided.During an interview on 7/29/2025 at 9:08 AM, Licensed Practical Nurse #3 stated that there was no system in place that triggers the staff to know they have educations due. There was a pile of mandatory educations near the time clock and the staff were supposed to take their education, do the test and sign that they did it. Licensed Practical Nurse #3 stated they had no time to get their educations done. There was no education given for Certified Nurse Aides that separated education for care of demented residents versus residents that had a mental illness as far as they knew. Licensed Practical Nurse #3 stated that it had been a while since they had been educated on the topic. They stated they could not say when the last time they were educated on the topic but the last time it happened, it had been the first time in a long time that it had happened at all.During an interview on 7/29/2025 at 9:30 AM, Staffing Coordinator #1 stated that they were not involved with education of nursing staff but knew that there were baskets full of handouts staff were supposed to take, complete, and return to Director of Nursing #1 who was also the Nurse Educator.During an interview on 7/30/2025 at 10:04 AM, Director of Nursing #1 who also the Nurse Educator, stated that they had been the nurse educator since September 2024. The new Assistant Director of Nursing was being trained to take over as Nurse Educator. Assistant Director of Nursing #1, also the Infection Preventionist, had just completed taking the Preventionist course and now that they had finished that, they were working on getting them ready take over education in the building. They stated When Director of Nursing #1 started, the annual educations that had already been done were unable to be located so they had to start from scratch and create a tracking system. Director of Nursing #1 stated that getting educations organized was their weekend project and provided tracking binders, sporadically filled out, as examples of what the intended end product would look like. Director of Nursing #1 stated that monthly educations were put out near the time clock for staff to do and sign off that they were done. Director of Nursing #1 stated that they did not have time to audit the educations as much as they should and that there were not enough staff to pull them off the units to do education at this time. Director of Nursing #1 stated they had not been at the facility for a year and therefore was unable to speak to yearly evaluations as they had not yet been completed. Educations have been ad hoc based on house wide practices noted to be problematic. They stated they deal with issues as they popped up at this time.Director of Nursing #1 stated they had plans to do education on the difference between caring for residents with mental illnesses versus residents with dementia and Alzheimer's. They stated they also wanted to do training on personal safety when dealing with aggressive residents.During an interview on 7/30/2025 at 11:41 AM, Corporate Administrator #1 stated that the facility needed a lot of work after their last survey and that the staff had been focusing on the major problem areas and creating organization for processes to be implemented. They stated educations would be done. The focus had been working on behavior management and medication reduction. 10 New York Codes, Rules, and Regulations 415.26(c)(1)(iv)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on an observation, record review, and interviews conducted during the recertification survey, it was determined that the facility did not post nurse staffing information in an area accessible to all residents and visitors, as required by the posting requirements. Specifically, daily nurse staffing levels for staff working in the facility on each shift was not posted in the facility on July 21, 2025, through July 25,2025, and July 28, 2025, through July 29, 2025.This is evidenced by:Facility Policy titled, Posted Nurse Staffing Information, last revised 09/2024, documented it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The nursing staffing sheet would be posted on a daily basis at the beginning of each shift. The information posted would be presented in a clear and readable format and in a prominent place readily accessible to residents and visitors.During an observation on 7/22/2025 at 11:50 AM, nurse staffing information was not posted at the reception desk, in the lobby, or on any units or hallways within the facility.During an interview on 7/29/2025 at 9:30 AM, Staffing Coordinator #1 stated nurse staffing information was to be posted at the receptionist's desk. They further stated that staffing information was not posted there because they had not had the time to do it while the survey team was onsite. 10 New York Codes, Rules, and Regulations 415.13

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5 percent for Four (4) (Resident #33, 36, 76, and 11) of four (4) residents observed during medication administration with 25 observations. This resulted in a medication error rate of 84 percent.This is evidenced by:The Facility's Policy and Procedure titled; Administering medications, effective 1/2024, documented a licensed nurse will be responsible for passing medications to residents in accordance with techniques approved for use in the facility, in compliance with New York State Codes, rules and regulations ad with other applicable Federal and State Laws. Medications will be administered using the six rights of medication administration: right resident, right medication, right dose, right time, right route, right documentation. If medication supply is found to be equal or less than 7 days, the refill icon should be clicked to initiate resupply. Medication administration must be charted in the Medication Administration Record (MAR) immediately before going on to the next resident, as follows: Documentation to indicate medication was given as ordered.Resident #36Resident #36 was admitted with a diagnoses of chronic obstructive pulmonary disease (a group of lung diseases characterized by persistent and progressive airflow obstruction and chronic respiratory symptoms), polyneuropathy (a condition where multiple peripheral nerves in the body are damaged, leading to a range of symptoms due to impaired nerve function), lower extremity gangrene (a condition where tissue dies due to a lack of blood supply), status post amputation. The Minimum Data Set (an assessment tool) dated 4/28/2025 documented the resident's cognition was intact and could understand and be understood by others.Resident #36 Medication Administration Record dated July 2025 documented, Gabapentin 300 milligram capsule: Give 1 capsule (300 milligram) by oral route 2 times per day at 8:00 AM and 8:00 PM Breo Ellipta 100 micrograms-25 microgram/dose powder for inhalation: Inhale 1 puff by inhalation route once daily at 9:00 AM Ensure Plus (Strawberry) 240 milliliters at 9:00 AM Slow-Mag 71.5 milligram tablet delayed release: Take 1 tablet by oral route once daily at 9:00 AM Pro Stat 30 cubic centimeters orally twice daily at 9:00 AM Multivitamin with minerals-ferrous fumarate 15 milligram iron tablet: Give1 tablet by oral route once daily at 9:00AM Potassium chloride ER 20 milliequivalent tablet: Give 1 tablet (20 milliequivalent) by oral route 2 times per day with food at 8:00 AM and 8:00 PM Furosemide 40 milligram tablet: Give 1 tablet (40milligrams) by oral route once daily at 9:00 AM Docusate sodium 100 milligram capsule: Give 1 capsule (100 milligrams) by oral route 2 times per day at 8:00 AM and 8:00 PM Carvedilol 6.25 milligram tablet: Give 1 tablet (6.25 milligram) by oral route 2 times per day with food at 8:00 AM and 8:00 PM. Aspirin 81 milligram tablet, delayed release: Give 1 tablet (81 milligram) by oral route once daily for 10 days Start Date: 04/22/2025 7:07 AM Amlodipine 10 milligram tablet. Give 1 tablet (10 milligram) by oral route once daily at 9:00 AM During an observation on 7/29/2025 at 10:35 AM, Registered Nurse #1 administered the following medications prescribed for 8:00 AM at 10:35 AM: docusate sodium 100 milligram capsule Carvedilol 6.25 milligram tablet Potassium chloride ER 20 milliequivalent tablet Gabapentin 300 milligram capsuleDuring an observation on 07/29/2025 at 10:35 AM, Registered Nurse #1 administered the following medications prescribed for 9:00 AM at 10:35 AM: Pro Stat 30 cubic centimeters Amlodipine 10 milligram tablet. furosemide 40 milligram tablet Multivitamin with minerals-ferrous fumarate 15 milligram iron tabletDuring an observation on 7/29/2025 at 10:35 AM, Registered Nurse #1 administered Aspirin 81 milligram tablet, delayed release after its 10-day order expiration date, without obtaining order clarification or renewal order: The Physician order documented Give 1 tablet (81 milligram) by oral route once daily for 10 days Start Date: 4/22/2025 7:07 AM. During an observation on 7/29/2025 at 10:35 AM, Registered Nurse #1 did not administer Breo Inhaler Ellipta 1 Puff as order at 9:00AM, and Ensure supplement as ordered for 9:00 AM. Initially Breo inhaler medication was not available; then Resident #36 stated to Registered Nurse #1 that they did not take this medication or supplement anymore. Registered Nurse #1 did not verify orders; did not re-order medication, instead withheld medication and supplement. Both Breo Inhaler and Ensure Nutritional Supplement were signed as given on previous day by Registered Nurse #2.During an observation on 7/29/2025 at 10:35 AM, Registered Nurse #1 did not administer Slow-Mag 71.5 milligram tablet delayed release as ordered for 9:00AM. Registered Nurse #1 stated the medication was not available and was unable to give. Resident #76Resident #76 was admitted to the facility with diagnoses of cerebral palsy (group of disorders that affect movement, balance, and posture due to damage to the developing brain), muscle weakness, and major depressive

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	335389	A. Building B. Wing	07/30/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for two (2), (South and East Units) of three (3) medication rooms reviewed, and four (4) (East Unit Cart #1; North Unit Cart #1 and #2; South Unit Cart #1) of six (6) medication carts reviewed. Specifically, (a.) one (1) open bottle of purified protein derivative (PPD) had expired; (b.) one (1) vial of COVID 19 vaccine mRNA Comirnaty had expired; (c.) Jevity tube feed formula was stored in resident's room; (d.) pre-poured medication was found stored in medication cart; (e.) one (1) empty inhaler was found in cart. (f.) two (2) open inhalers had no open and or expiration date; (g.) three (3) open bottle of eye drops had no open and or expiration date, and (h.) one (1) bottle of eyedrops belonging to cart #1 found in cart #2.This is evidenced by:The Facility ' s Policy and Procedure titled, Storage of Drugs, effective 3/2023, documented drugs shall be stored in an orderly manner in cabinets, drawers or carts or sufficient size to prevent crowding. All medications and other drugs, including treatment items, shall be stored in a locked cabinet inaccessible to residents and visitors. Drugs shall not be kept on hand after the expiration date on the label, and no contaminated or deteriorated drugs shall be available. Drug storage areas in the medication cart shall not contain non-drug items.The Facility ' s Policy and Procedure titled; administering medications, effective 1/2024, documented a medication must never be left at the bedside or be out of sight of the medication nurse. Administration of Controlled Substances: The medication is prepared or administration at the resident's bedside. Immediately following preparation of the medication for administration, the amount to be administered is recorded on the specific resident's Controlled Substance Inventory form. Medication administration is recorded after the administration of the medication to the resident. If for any reason, the resident refuses, the medication becomes contaminated, or there is a medical reason to withhold the medication, then the medication documentation is entered into the Medication Administration Record indicating not given and the reason why. If the controlled medication is not given, then the medication nurse needs to seek another licensed nurse to witness the appropriate ad irretrievable wasting of the controlled drug. Both nurses' signatures are required as documentation of this event, both on the controlled substance log and in the electronic medication administration record.During an observation on [DATE] at 2:55 PM, the North Unit Medication Room refrigerator contained one (1) open bottle of purified protein derivative (PPD) with open date of [DATE]. A tuberculin PPD vial, once opened, should be discarded 30 days after opening or when it reaches the manufacturer's expiration date, whichever comes first Per Manufacturer's insert A vial of TUBERSOL which has been entered and in use for 30 days should be discarded.During an observation on [DATE] at 3:03 PM, East Unit Medication Cart #2 contained a pre-poured medication cup with one (1) clonazepam 0.5 milligram tablet prescribed for Resident #8. The medication was signed out in narcotic book and in electronic medical record at 1:19 PM. The medication was brought and administered to the resident at 2:26 PM. The cart also contained one (1) empty Atrovent inhaler; one (1) Atrovent inhaler and one (1) Dulera inhaler both had no open and or expiration dates.During an observation on [DATE] at 8:19 AM, North Unit Medication Cart #1 contained three (3) bottles of Latanoprost eye drops with no open and or expiration date. Three (3) open over the counter medications had no open dates (Tylenol, Senna and Multivitamins). During an observation on [DATE] at 8:30 AM, North Unit Medication Cart #2 contained one (1) bottle of Latanoprost eyedrops belonging to cart #1 found in cart #2.During an observation on [DATE] at 11:20 AM, South Unit Medication Room refrigerator contained COVID 19 vaccine mRNA Comirnaty with an expiration date of [DATE].During an observation on [DATE] at 2:18 PM, four (4) bottles of Jevity Tube Feed were at Resident #50's bedside. One (1) of those bottles were opened with approximately 200 milliliters remaining in bottle. During an interview on [DATE] at 03:03 PM, Licensed Practical Nurse #2 stated when the medication was brought to the resident, they were asleep. Licensed Practical Nurse #2 stated they should have awakened resident and given the medication.During an interview on [DATE] at 11:22 AM, Licensed Practical Nurse #3 stated the over-the-counter stock medications should be labeled with an open date. During an interview on [DATE] at 2:41 PM, Director of Nursing #1 stated per the Medication Administration Policy nurses cannot pre-pour medications. If a medication is pre-poured and the resident became unavailable or refused, the medication should be discarded. It is the responsibility of each nurse to ensure their mediation cart is clean and orderly prior to passing medications. They also stated upon opening a multivial medication, the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the recertification and abbreviated survey (Case #664249), the facility did not ensure that posted menu items were served, that notification was provided when menu items were substituted and that individual food preferences were honored for five (5) (Resident #'s 11, 14, 40, 47, and 97) of five (5) residents reviewed. Specifically, residents were not served posted menu items, food preferences, or food items that were listed on the meal tray tickets. Additionally, residents were not notified of menu substitutions.this is evidenced by:The Facility Policy titled; Food and Nutrition revised 04/2024 documented that it was the policy of the facility to ensure that facility staff support the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet. The facility would provide each resident with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Each resident would receive, and the facility would provide at least three meals a day.Resident #11Resident #11 was admitted to the facility with diagnoses of multiple sclerosis (a chronic, often debilitating disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and bod), dysphagia (difficulty swallowing), and type 2 diabetes (a chronic condition where the body either does not produce enough insulin or cannot properly use the insulin it produces). The Minimum Data Set (an assessment tool) dated 6/26/2025, documented the that the resident was cognitively intact, could be understood, and could understand others.During an interview on 7/21/2025 at 12:50PM, Resident #11 stated the menu was sent around, but the meal was never correct. The kitchen served whatever they wanted to serve. They stated they were not given a chance to choose their lunch meal that day. Resident #11 stated when they would ask for an alternate, sometimes they were served something else, sometimes they were not. They stated they had not gotten tea for 8 months as per their preference. They further stated that they had gone to Resident Council and told them about their issues with the food/menu and nothing was done about it.During an observation on 7/21/2025 at 12:50PM, Resident #1 was served their lunch. The meal ticket read tator tots, but they were served mashed potatoes. They were also not served tea, as was indicated on the meal ticket. Resident #40Resident #40 was admitted to the facility with diagnoses of asthma (a respiratory condition marked by spasms in the lungs causing difficulty breathing), gastro-esophageal reflux disease (a condition in which acidic gastric fluid flows backward into the esophagus resulting in heartburn), and dysphagia (difficulty swallowing). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #40 stated that alternative items were frequently unavailable.During an interview on 7/28/2025 at 12:13 PM, Resident #40 stated that they rarely got a meat or protein item on their food tray. They stated that they had no choice on what they were served. They took what they were given. Resident #40 stated there were no choices and no advance menu. Resident #40 stated that after they were served eggs multiple times, although the resident was not able to eat eggs, they took their tray to the kitchen themselves, made the kitchen staff look at their tray, and their ticket which said, no eggs and asked them to explain why they continued to get eggs. Resident #40 stated the kitchen stopped sending eggs after that.During a tray sampling on 7/28/2025 at 12:05 PM, Resident #40's tray was provided. The meal ticket read peaches however, the mixed fruit cup was made up of both peaches and pears.Resident #47Resident #47 was admitted to the facility with diagnoses of fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), type 2 diabetes, and morbid obesity due to excess calories (a severe form of obesity characterized by an extremely high body mass index). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, could be understood, and understood others.During an interview on 7/22/2025 at 12:38 PM, Resident #47 stated that they were told by kitchen staff that the kitchen was having problems with orders. They stated the Dietitian had offered to bring them a new menu to cross out items they did not like, but that never happened. They stated the menu had not changed since December 2024 and that residents could not ask for alternates, because the kitchen would often not have any. Resident #47 stated, you never knew what you would be served. Resident #47's roommate was present during the interview and agreed. During a tray sampling on 7/29/2025 at 8:15 AM, Resident #47's food tray was provided. The meal ticket documented that there would be nondairy creamer, orange juice, and cottage cheese. Coffee was observed to be served separately from the breakfast

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Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews conducted during the recertification and abbreviated survey (Case # 664249), the facility did not ensure that food and drink were palatable and attractive for seven (7) (Resident #s 6, 14, 19, 40, 47, 87, and 97) of seven (7) residents reviewed for palatable and attractive food and drink. Specifically, Resident #s 6, 14, 19, 40, 47, 87, and 97 complained of food being cold, unattractive, and not palatable. This is evidenced by: Facility Policy titled, Food Safety Requirements Policy, last revised 5/01/2025, documented that it was the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors. Additionally, the facility procures food from sources approved or considered satisfactory by federal, state or local authorities. This included storage, preparations, distribution, and serving food in accordance with professional standard for food service safety.Facility Policy titled, Food and Nutrition Services, last revised 4/2024, documented that it was the policy of the facility to ensure that facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about their diet. The facility would provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Suitable, nourishing alternative meals and snacks would be provided to residents who wanted to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.Resident #6Resident # 6 was admitted to the facility with diagnoses of type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces), severe morbid obesity (a severe form of obesity characterized by an extremely high body mass index), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 3/24/2025, documented that the resident was cognitively intact, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #6 stated that their food was unappetizing, and that alternative items were frequently unavailable. Additionally, Resident #6 believed that the portions were too small, and the juice had no flavor.Resident #40Resident #40 was admitted to the facility with diagnoses of asthma (a respiratory condition marked by spasms in the lungs causing difficulty breathing), gastro-esophageal reflux disease (a condition in which acidic gastric fluid flows backward into the esophagus resulting in heartburn), and dysphagia (difficulty swallowing). The Minimum Data Set, dated [DATE], documented that the resident had intact cognition, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #40 stated that their food was unappetizing, and that alternative items were frequently unavailable.During an interview on 7/28/2025 at 12:13 PM, Resident #40 stated that they rarely got meat or protein item on their tray. Resident #40 stated that they had no choice on what they were given. Resident #40 stated they took what staff gave them. There were no choices, and no advance menu. Resident #40 stated that after they were served eggs multiple times, and the resident was not able to eat eggs, the resident took their tray to the kitchen themselves, made the kitchen staff look at their tray, and their ticket which said, no eggs and asked them to explain to why Resident #40 continued to get eggs. Resident #40 stated after they did that, the kitchen stopped sending eggs to them.Resident #47Resident #47 was admitted to the facility with diagnoses of fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), type 2 diabetes (a chronic condition where the body either does not produce enough insulin or cannot properly use the insulin it produces), and morbid obesity due to excess calories (a severe form of obesity characterized by an extremely high body mass index). The Minimum Data Set, dated [DATE], documented that the resident had intact cognition, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #47 stated that their food was unappetizing, and that alternative items were frequently unavailable.During an interview on 7/22/2025 at 12:38 PM, Resident #47 stated the food was bad. Food was burnt or raw. Vegetables were overcooked. Resident #47 stated they were supposed to get double protein, but usually only got one serving and were lucky if they got a salad once a month. Resident #47 stated that the kitchen staff stated they were having problems with orders. The facility Nutritionist stated they would bring a new menu to cross out things Resident #47 did not like, but that never happened. The menu had not changed since December 2024. People could not ask for alternates, because the kitchen did not usually have them. During an interview on 7/29/2025 at 8:20 AM, Resident #47 agreed to allow this surveyor to test their tray for

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Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that each resident received, and the facility provided food that accommodated resident allergies, intolerances, and preferences, and appealing options of similar nutritive value to residents who choose not to eat food that was initially served or who requested a different meal choice. Specifically, seven (7) out of eight (8) residents at a surveyor led Resident Council meeting reported they were not able to get substitutions or an alternative menu option.This is evidenced by: A facility policy titled Food and Nutrition Services, date revised 4/2024, documented that it was the policy of the facility to ensure that facility staff supports the nutritional well-being of the residents while respecting an individual's right to make choices about his or her diet. Under procedures, documented was the following. The facility would provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 10. Suitable, nourishing alternative meals and snacks would be provided to residents who wanted to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.Resident #6Resident # 6 was admitted to the facility with diagnoses of type 2 diabetes (a chronic condition where the body either does not produce enough insulin or cannot properly use the insulin it produces), severe morbid obesity (a severe form of obesity characterized by an extremely high body mass index), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 3/24/2025, documented that the resident was cognitively intact, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #6 stated that their food was unappetizing, and that alternative items were frequently unavailable.Resident #40Resident #40 was admitted to the facility with diagnoses of asthma (a respiratory condition marked by spasms in the lungs causing difficulty breathing), gastro-esophageal reflux disease (a condition in which acidic gastric fluid flows backward into the esophagus resulting in heartburn), and dysphagia (difficulty swallowing). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #40 stated that that alternative items were frequently unavailable.During an interview on 7/28/2025 at 12:13 PM, Resident #40 stated that they rarely got meat or protein item on their tray. Resident #40 stated that they had no choice on what they were given. Resident #40 stated they take what they gave them. There were no choices, and no advance menu. Resident #40 stated that after they were served eggs multiple times, and the resident could not eat eggs, the resident took their tray to the kitchen themselves, made the kitchen staff look at their tray, and their ticket which said, no eggs and asked them to explain to why Resident #40 continued to get eggs. Resident #40 stated after they did that, the kitchen stopped sending eggs to them.Resident #47Resident #47 was admitted to the facility with diagnoses of fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or can't properly use the insulin it produces), and morbid obesity due to excess calories (a severe form of obesity characterized by an extremely high body mass index). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, could be understood, and understand others.During Resident Council meeting on 7/22/2025 at 10:32 AM, Resident #47 stated that their food was unappetizing, and that alternative items were frequently unavailable.During an interview on 7/22/2025 at 12:38 PM, Resident #47 stated the food was bad. Food was burnt or raw. Vegetables were overcooked. Resident #47 stated they were supposed to get double protein, but usually only got one serving and were lucky if they got a salad once a month. Resident #47 stated that the kitchen staff stated they were having problems with orders. The facility Nutritionist stated they would bring a new menu to cross out things Resident #47 did not like, but that never happened. The menu had not changed since December 2024. They stated residents could not ask for alternate, because the kitchen did not usually have them.During an interview on 7/23/2025 at 1:27 PM, Kitchen Director #1 stated that they were no longer allowed to order directly from the distributers. Unfortunately, now when they placed the order, they did not know if the kitchen would be out of anything until the order arrived. When that happened Kitchen Director #1 stated they had to make changes to the menu on the fly. Corporate had said that they were setting something up with the shipping company so that they could email someone before the shipment went out to let the facility know if things would be missing and hopefully after that happened, the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	335389	A. Building B. Wing	07/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification and abbreviated survey (Case # 664249), the facility did not maintain medical records in accordance with accepted professional standards and practices, as accurately documented and completed for six (6) (Resident #'s 2, 3, 16, 44, 77, and 97) of the 30 residents reviewed. Specifically, (a.) Resident #2 was observed to be unkempt and in need of assistance to perform activities of daily living, there was no documented evidence of care provided; (b.) Resident #3 medications and monitoring of behaviors were not documented as completed; (c.) Resident #16 did not have weekly skin checks and showers documented as completed; (d.) Resident #44 did not have weekly skin checks and showers documented as completed; (e.) Resident #77 reported they had not received a shower, there was no documented evidence that resident had been given a shower, and an order for skin checks under a wrist brace was not entered correctly into the Treatment Administration Record; and (f.) Resident #97 reported that they were not regularly offered or provided the opportunity to shower, despite being care planned to receive showers twice a week because of a fungal infection. There was no documented evidence that resident was offered showers twice a week.Resident #2Resident #2 was admitted to the facility with the diagnoses of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a range of other symptoms that significantly impact daily life), and atrial fibrillation (an irregularly heartbeat). The Minimum Data Set (an assessment tool), dated 7/02/2025, documented the resident was able to understand others, be understood, and was severely cognitively impaired.During a general observation of the unit on 7/21/2025 at 10:52 AM, Resident #2 was still in bed, still sleeping, and did not appear to have been gotten up or cleaned up for the dayResident #2's Comprehensive Care Plan for Activities of Daily Living dated 11/30/2024 documented the resident required daily support of a minimal one assist staff member to shower related to their cognitive status. There was no documented day or shift for the weekly shower.The Treatment Administration Record for July 2025 did not have documented evidence that Resident #2 was provided a shower.The Treatment Administration Records for June 2025 documented Resident #2 received a shower or bath on 6/14/2025, and 6/28/2025.Resident #3 Resident #3 was admitted to the facility with the diagnoses of Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement), unspecified dementia, and essential hypertension (high blood pressure). The Minimum Data dated 6/30/2025 documented the resident was rarely/never understood by others, could rarely/never understand others, and was severely cognitively impaired. The Medication Administration Record for July 2025 documented the following medications were not documented as administered:- Quetiapine 25 milligrams (an antipsychotic medication) did not have documented evidence as administered on 7/02/2025 at 4:00 PM and 8:00 PM, 7/12/2025 at 4:00 PM and 8:00 PM, 7/16/2025 at 4:00 PM and 8:00 PM- Famotidine 20 milligrams (antacid medication) did not have documented evidence as administered on 7/02/2025 at 8:00 PM, 7/12/2025 at 8:00 PM, 7/16/2025 at 8:00 PM- Acetaminophen arthritis pain 650 milligrams (non-opioid pain medication) did not have documented evidence as administered on 7/02/2025 at 8:00 PM, 7/12/2025 at 8:00 PM, 7/16/2025 at 8:00 PM- Artificial Tears 1.4% eyedrops (for dry eyes) did not have documented evidence as administered on 7/02/2025 at 8:00 PM, 7/12/2025 at 8:00 PM, 7/16/2025 at 8:00 PM- Tamsulosin 0.4 milligram (medication to treat urinary retention) did not have documented evidence as administered on 7/02/2025 at 9:00 PM, 7/12/2025 at 9:00 PM, 7/16/2025 at 9:00 PM- Atorvastatin 10 milligrams (medication to treat high cholesterol) not documented as administered on 7/02/2025 at 8:00 PM, 7/12/2025 at 8:00 PM, 7/16/2025 at 8:00 PM- Behaviors every shift did not have documented evidence as completed on 7/02/2025 3:00 PM-11:00 PM shift, 7/12/2025 3:00 PM-11:00 PM shift, and 11:00 PM-7:00 AM shift, 7/16/2025 3:00 PM-11:00 PM shiftResident #16Resident #16 was admitted to the facility with the diagnoses malignant neoplasm of left kidney (cancerous tumor characterized by uncontrolled cell growth that can invade nearby tissues and spread to other parts of the body), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs). The Minimum Data Set, dated [DATE] documented the resident could be understood, understand others, and was cognitively intact. During an observation on 7/29/2025 at 8:51 AM, Resident #16 was noted to have a large bruise on their left outer leg, from knee to

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on record review and interviews conducted during a recertification survey, the facility did not ensure the Quality Assurance and Performance Improvement committee developed and implemented appropriate plans of action to correct identified quality deficiencies as well as opportunities for improvement. Specifically, the facility had repeat deficiencies in the areas of Baseline Care Plan (F655), Develop/Implement Comprehensive Care Plan (F656), Care Plan Timing and Revision (657), staffing (F725), Competent Nursing Staff (726), and Label/store/Drugs and Biologicals (F761).This is evidenced by:The Facility Quality Assurance and Improvement Policy dated 05/2025, documented it is the policy of the facility to evaluate our residents experience of the services facility provides to determine how the experience can be improved, to realize our vision of innovation and continuous improvement in the delivery of care. To accomplish our purpose, we engage all members of each service to evaluate the quality of care we provide to our residents and hold ourselves to the highest standard by continually improving the care of the resident's behalf. Documented in Element III - Feedback, Data Systems and Monitoring, was that following: Pertinent resident care information would be reviewed daily by Interdisciplinary Team; daily morning minutes (running log or needed follow up for each unit) will be reviewed and revised on an ongoing basis by Interdisciplinary Team; any areas that needed immediate Performance Improvement would be identified and followed up by Quality Assurance Steering Committee as indicated; the facility would utilize multiple data sources to monitor performance including Quality Measures, State and National benchmarks as well as tracking and investigating any adverse events affecting residents. Feedback from staff would be encouraged and welcomed via Unit Quality Improvement rounds, regular meetings and open door policy by Department Heads and Administration. Quality Improvement alert would be distributed to each Department Head for staff educations as indicated.During an interview on 7/30/2025 at 10:04 AM, Director of Nursing #1 stated that they had been the nurse educator since September 2024. The new Assistant Director of Nursing who started in March 2025 was in training to take on the role. Assistant Director of Nursing #1 started as the Infection Control Preventionist upon hiring at the facility. That certification had recently been completed and therefore, they would be able to focus on education now. They stated during the onsite survey, there was a particularly high instance of late medications, and because of that, Assistant Director of Nursing #1 was working with the nursing staff to ensure better performance. The gap in the system, which lead to the outcome of a high medication error rate, was not known to the Director of Nursing or the Corporate Administrator until it had occurred while survey was happening. Director of Nursing #1 stated that they had to work on facility related tasks every day, including off hours and weekends because there were so many things that needed to be done. The previous administration and high-level nursing left minimal information and a mess when they left, and the new staff were brought in. Director of Nursing #1 stated they felt supported by their corporate structure, but the culture of nursing care had changed. Director of Nursing #1 stated that their door was always open for residents and staff to come and talk to them regarding issues within the facility. Director of Nursing #1 stated that they had not been employed at the facility for a full year yet and there were so many issues when they arrived, that they started with what they believed to be the most egregious issues and went from there. There were not enough staff currently to be able to pull them off the units to do educations or one on one performance improvement plans. Director of Nursing #1 also stated that they were not able to audit staff educations as often as they should because of the amount of work they needed to do. Educations had been ad hoc based on house wide practices noted to be problematic.During an interview on 7/30/2025 at 11:41 AM, Corporate Administrator #1 stated that they were treating the facility as all hands-on deck. It was expected that everyone in the building needed to pitch in. Quality Assurance Performance Improvement met every three months. Some corporate people came to the meetings; however, the Regional Director of Operations had just left the organization so Corporate Administrator #1 was covering a lot of people's positions. Corporate Administrator #1 stated that they would be at the next Quality Assurance Performance Improvement meeting because they were in the facility for the survey. Performance Improvement Plans were done with people as needed. Working on reducing fall rates, behavior management, and psychotropic medications were the focus when they all started at the facility. Corporate Administrator #1 stated that when issues were identified, the Performance Improvement Plan would start. Some of the issues identified during the survey process were not known to Corporate Administrator #1 prior to being pointed out. Issues like inventorying resident belongings was known because it was brought up by resident council. Food supply

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (Case #664249), the facility did not maintain a pest-free environment and an effective pest control program on two (2) of two (2) resident units. Specifically, insect infestation was found in resident rooms, the main kitchen, and staff areas.This is evidenced by:During observations on 7/21/2025 through 7/30/2025 between 8:00 AM and 5:00 PM fly activity was always identified in the below locations throughout the duration of the survey at various intensities noted in the North Unit activity room which was provided to the team as the survey team meeting area.During initial interviews on 7/21/2025 at 10:58 AM, flies were noted to be in the room of Resident #10.During an interview on 7/21/2025 at 12:22 PM, flies were noted to be in the office of Regional Nursing Coordinator #1.During initial interviews on 7/21/2025 at 1:22 PM, small flying insects were noted in the bathroom of Resident #87.During a test tray observation on 7/29/2025 at 8:16 AM, flies were noted in the room of Resident #47.There was no evidence that the facility maintained a Pest control Management book.During an interview on 7/21/2025 at 12:00 PM, Director of Maintenance #1 stated that the vendor had treated for flies last Friday (7/18/2025) but they had not yet received the report and invoice for the work performed. 10 New York Codes, Rules and Regulations 415.29(j)(5)