STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335398	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sans Souci Rehabilitation and Nursing Center	115 Park Avenue Yonkers, NY 10703

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (NY00352230), the facility did not ensure a resident's right to be free from abuse for 1 out of 3 residents (Resident #3) reviewed for abuse. Specifically, on 8/22/2024 Certified Nurse Aide #1 witnessed Resident #2 with a known history of inappropriate behaviors towards staff and others, striking Resident #3 (who had a history of wandering behavior and was care planned for supervision) on the head with a flexi-bar (rubber cylinder used in therapy) from behind. The investigative conclusion documented there is no evidence that any alleged abuse had occurred. The Findings are: 1) Resident #2 was admitted to the facility on [DATE] with diagnoses including but not limited to Acquired Absence of Left Leg Above Knee, Unspecified Psychosis and Mood Disorder. Review of a Quarterly Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident had impairment on one side of the lower extremity. The resident required a walker or a wheelchair for locomotion. The resident was independent for eating and bed mobility and supervision with toileting and transferring. Review of a risk to be a victim of abuse care plan initiated 3/25/2024 and revised 8/22/2024 documented Resident #2 had an allegation of abuse against them by their previous roommate. The care plan also documented allegation of sexual inappropriate behavior reported by staff. Interventions included for resident to be always assisted by 2 staff for all cares, psychiatry/psychology evaluation and that the resident will not abuse any other resident through the next review date. 2) Resident #3 was admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Muscle Weakness and Diabetes Mellitus. A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment and exhibited wandering behaviors. The resident used a wheelchair and a walker for locomotion. The resident required set up assistance with eating, supervision with toileting, bed mobility and transfers. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Actual /potential for Abuse /neglect created 7/2022 documented the resident was found in another resident's room on 7/30/2024 with their head at the foot of the bed facing the door. Resident had another resident poured a cup of liquid on them. Interventions included x30min checks which was initiated 7/30/2024, psychiatry/psychology evaluation, refer to recreational activities, staff to monitor and redirect as needed. Review of the facility investigative summary, that is unsigned and undated documented that on 8/22/2024 at around 1:30 PM, an incident occurred involving Resident #2 and Resident #3. The Director of Nursing was informed by Licensed Practical Nurse #2 that Resident #2 hit Resident #3 on the head. Certified Nurse Aide #1 and Certified Nurse Aide #2 witnessed the incident, and reported that Resident #2, who was wheeling themselves behind Resident #3, verbally expressed frustration by stating they took their blanket. Subsequently, Resident #2 used a little flexi-bar (rubber cylinder used for therapy) to strike Resident #3 from behind. Certified Nurse Aide #1 and Certified Nurse Aide #2 were present in the hallway and intervened immediately and prompted Resident #3 to return the blanket to Resident #2, which they did. The investigative conclusion documented Resident #3 was moved to another room and Resident #2 was transferred to the hospital for a psychological evaluation. It was concluded that Resident #3's severe cognitive impairment affecting their memory, behavior and mobility made it challenging to navigate the facility correctly and locating their room, leading to them entering Resident #2's room. Staff to continue to routinely check the hallway to redirect and prevent residents from wandering and entering other residents' rooms and intervene when needed to redirect residents with behavioral episodes and prevent any altercation. The investigation documented that there was no evidence that any alleged abuse had occurred. During an interview on 3/10/2025 at 12:20 PM, Certified Nurse Aide #1 stated they were sitting at the nurse's station on the 3rd floor, and they heard loud speaking, and they went to the noise and saw Resident #2 and Resident #3. Certified Nurse Aide #1 stated Resident #2 was behind Resident #3, and they then tapped Resident #3 on the back of the head with a rubber cylinder used in therapy. Certified Nurse Aide #1 stated they went behind Resident #2 and took the cylinder and asked what was going on. Certified Nurse Aide #1 stated Resident #2 was upset and stated Resident #3 who was confused had gone into their room by accident, but that it kept happening. Certified Nurse Aide #1 stated Resident #3 had a room change and they were confused and would forget where their room was located. Certified Nurse Aide #1 stated they separated Resident #2 and Resident #3 and reported the incident to the nurse. Certified Nurse Aide #1 stated they were by themselves and were the only witness when Resident #2 hit Resident #3 on the back of the head. By the time they got to the residents, another certified nurse aide showed up. During an interview on 3/13/2025 at 11:19 AM, the Director of Nursing #1 stated they determined no abuse occurred for the incident that occurred on 8/22/2024 because they went and spoke with Resident #2 who they stated they were playing with Resident #3 when they hit them on the back of the head. The Director of Nursing #1 stated they assessed Resident #3, and they did not have any injury. The Director of Nursing #1 stated Resident #2 knew what they were doing, and they were not trying to intentionally hurt Resident #3. The Director of Nursing #1 stated the entire time Resident #2 was laughing and thought it was funny, but they have psychiatric issues. 10NYCRR 415.4(b)(1)(i)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (NY00352230, NY00331567), the facility did not ensure the report of the results of an investigation was submitted to the New York State Department of Health in accordance with State law within 5 working days of the incident for 3 out of 3 residents (Resident #2, Resident #3, Resident #4) reviewed for abuse. Specifically, (1) On 8/22/2024, Resident #2 was witnessed by Certified Nurse Aide #1, hitting Resident #3 on the back of the head with a flexi-bar (rubber cylinder used for therapy). Review of the 5-day investigative conclusion submission revealed it was not submitted to the New York State Department of Health until 8/28/2024; (2) On 1/14/2024, Resident #4 exited the facility through the front door unescorted and was found in a neighboring yard, the resident was taken to the hospital by emergency medical services. Review of the investigative summary revealed no documented evidence of the 5-day investigative conclusion being submitted to the New York State Department of Health. The findings are: The facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 6/3/2024 documented it is the policy of the facility to ensure all reports of resident abuse are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Within five business days of the incident, the administrator will provide a follow up investigation report. The follow up investigation report will provide sufficient information to describe the results of the investigation. 1) Resident #2 was admitted to the facility with diagnoses including but not limited to Acquired Absence of Left Leg Above Knee, Unspecified Psychosis and Mood Disorder. Review of a Quarterly Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident had impairment on one side of the lower extremity. The resident required a walker or a wheelchair for locomotion. The resident was independent for eating and bed mobility and supervision with toileting and transfers. 2) Resident #3 admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Muscle Weakness and Diabetes Mellitus. A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment and exhibited wandering behaviors. The resident used a wheelchair and a walker for locomotion. The resident required set up assistance with eating, supervision with toileting, bed mobility and transfers. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigative summary, unsigned and undated documented on 8/22/2024 at around 1:30 PM, an incident occurred involving Resident #2 and Resident #3. The Director of Nursing was informed by Licensed Practical Nurse #2 that Resident #2 hit Resident #3 on the head. Certified Nurse Aide #1 and Certified Nurse Aide #2 witnessed the incident, and reported that Resident #2, who was wheeled themselves behind Resident #3. Resident #2 stated Resident #3 took their blanket and expressed frustration. Subsequently, Resident #2 used a little flexi-bar to strike Resident #3 from behind. Certified Nurse Aide #1 and Certified Nurse Aide #2 were present in the hallway and intervened immediately. The investigative conclusion documented Resident #3 was moved to another room and Resident #2 was transferred to the hospital for a psychological evaluation. The investigation revealed that there is no evidence that any alleged abuse had occurred. Review of the 5-day investigative conclusion submission revealed it was not submitted to the New York State Department of Health until 8/28/2024. 3) Resident #4 was admitted to the facility with diagnoses including but not limited to Muscle Weakness, Dementia and Generalized Anxiety Disorder. An admission Minimum Data Set, dated [DATE] documented Resident #4 had severe cognitive impairment with no behaviors noted. Resident #4 was ambulatory with impairment to both sides of their upper extremities and impairment to one side of their lower extremity. The resident required supervision with eating, moderate assistance with toileting, bed mobility and transfers and had no wander guard in use. Review of the investigative summary dated 1/14/2024 at 3:33 PM revealed Resident #4 left the facility dressed in weather appropriate clothing, wearing a brown colored coat. They exited the facility and shortly afterwards entered the yard of a nearby home. At approximately 4:21pm the staff began a search for Resident #4 and activated their missing person protocol. At approximately 4:31 PM while the search was still in progress emergency medical services arrived at the facility and informed the staff that Resident #4 was located in a neighbor's yard and the resident was taken to the emergency room for evaluation. The investigation concluded there is no evidence to support that any alleged resident Abuse, Neglect or Mistreatment had occurred. It documented that Resident #4 left the facility unescorted and was located shortly thereafter within close proximity to the facility. There was no documented evidence that a 5-day investigative conclusion report was submitted to the New York State Department of Health. During an interview on 3/13/2025 at 10:52 AM, the Director of Nursing #1 stated if a reportable occurs then the nursing staff is aware that there is a two-hour window for the incident to be reported. The Director of Nursing #1 stated if there is a suspicion or allegation of abuse the staff inform them immediately. They begin the process by gathering statements from the staff and the residents, and notification is made to the family. The Director of Nursing #1 stated on the weekends and off hours, the nursing supervisor in the facility will obtain the statements from staff, notify the residents family and evaluate the resident. The Director of Nursing #1 stated they are responsible to submit the initial information to the State and responsible for all the reporting in the facility, including the submission of the 5-day conclusion for the reportable incidents (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 11:19 AM, the Director of Nursing #1 stated they submitted the investigative conclusion for the incident that occurred on 8/22/2024 on 8/28/2024 because there was a weekend in between. During an interview on 3/13/2025 at 1:50 PM, the Administrator stated they are involved in the reporting to the Department of Health. The Administrator stated the incident that occurred on 1/14/2024 was handled by them and the Director of Nursing #2, but they vaguely remember the incident with Resident #4. The Administrator stated they believe that the 5-day conclusion was submitted for the incident that occurred on 1/14/2024. 10NYCRR 415.4(b)(1)(ii)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00353705, NY00352230, NY00332692), the facility did not ensure that an allegation of abuse was thoroughly investigated for 6 (Resident #1, #2, #3, #38, #39, #40) of 6 residents reviewed. Specifically, (1) on 9/8/2024 Resident #1 reported to Licensed Practical Nurse #1 that Resident #2 had touched them inappropriately in their private area while they were roommates. Review of the facility incident report revealed the certified nurse aides assigned to the third-floor unit on 9/8/2024 did not provide any written statements regarding the incident. Review of the investigative summary revealed it was not dated and was not signed indicating it was not reviewed by the Medical Director; (2) On 8/22/2024 Resident #2 was witnessed by Certified Nurse Aide #1 hitting Resident #3 in the back of the head with a Flexi-bar (a rubber cylinder used in therapy). The facility investigative conclusion documented there was no cause to believe abuse had occurred. Review of the investigative summary revealed it had not been signed off on by the Director of Nursing #1, the Administrator or the Medical Director as reviewed; (3) on 2/1/2024 Resident #38's Representative reported to the Administrator that Resident # 38 was missing $33.00 and all their credit cards. Charges were made on their card from 1/29/2024 through 1/31/2024. Statements were not obtained for all staff assigned to the first-floor unit from 1/29/2024 to 1/31/2024; (4) Resident # 39 reported that their disability and social security credit card were missing and that the Credit Card company informed them that items were charged on the card on 1/31/2024 in the Bronx and [NAME] Island. A Cash App transfer of $65 dollars was also made. Statements were not obtained from all staff assigned to the first-floor unit on 1/31/2024 to 2/1/2024; 5) Resident #40 alleged that on 2/1/2024 their social security credit card was missing and used at an ATM in the Bronx for $46.00 dollars. Per police officers, the cards were used in the Bronx, Valley Stream and [NAME] Island. Statements were not obtained for all staff assigned to the first-floor unit on 2/1/2024. No written statements were obtained from Certified Nurse Aide #4, the alleged perpetrator. The Findings are: The facility Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy dated 6/3/2024 documented it is the policy of the facility to ensure all reports of resident abuse are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. All allegations are thoroughly investigated. The Administrator initiates investigations. Interviews are conducted with staff members on all shifts, who have contact with the resident during the period of the alleged incident. 1) Resident #1 was admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Schizoaffective Disorder and Hemiplegia affecting Left Dominant Side. A Modification of Medicare-5 Day Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment. The resident exhibited physical behavioral symptoms directed towards others, rejection of care and wandering. The resident required a manual wheelchair for locomotion and had impairment to upper and lower extremities on both sides. The resident required moderate assistance for eating and was dependent for toileting, bed mobility and transfers. 2) Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Acquired Absence of Left Leg Above Knee, Unspecified Psychosis and Mood Disorder. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Quarterly Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident had impairment on one side of the lower extremity. The resident requires a walker or a wheelchair for locomotion. The resident was independent for eating and bed mobility and supervision with toileting and transfers. Review of the undated investigative summary documented that on 9/8/2024 at approximately 7:30 PM Registered Nurse #1 responded to a report from Resident #1 alleging that their former roommate Resident #2 had touched them inappropriately. Resident #1 with a Brief Interview for Mental Status (BIMS) of 9/15 reported that Resident #2 who had been their roommate until 9/6/2024 touched their private area that made them uncomfortable. Resident #1 stated they had asked Resident #2 to stop, which they listened to their request to stop. Resident #1 stated that Resident #2 who had previously assisted them with daily needs and sometimes touched their chest and legs, inappropriately touched them a few days prior to the report. Resident #1 felt uncomfortable but did not report the incident immediately. Resident #1 told Registered Nurse #1 that Resident #2 told them they wanted to be their brother and care for them. Resident #1 was told by Resident #2 not to tell staff about it. Resident #2 who had been relocated to another room on 9/6/2024 was interviewed by Registered Nurse #1 and Licensed Practical Nurse #1 and denied the allegations. Resident #2 maintained that their interactions with Resident #1 were limited to providing assistance with daily tasks. Review of the investigative conclusion documented the facility acted promptly to address and mitigate the situation by separating the residents and conducting thorough evaluations. No injuries, no physical or psychological changes were observed. The investigation concluded the investigation was completed and it is undetermined at this time. The investigative summary was not dated or signed by the Medical Director. The facility did not provide any documented evidence of written statements obtained from the certified nurse aides on duty on 9/8/2024 for the third-floor unit or Registered Nurse #1. Statements were attached from Resident #2, Licensed Practical Nurse #1 and Resident #1. During a telephone interview on 3/13/2025 at 10:25 AM, Registered Nurse #1 stated they do not recall writing a statement about the incident that occurred on 9/8/2024. The usual process would be to write a statement. During an interview on 3/13/2025 at 10:52 AM, the Director of Nursing #1 stated all staff on the unit were interviewed regarding the allegation made on 9/8/2024. The Director of Nursing #1 stated they did not obtain statements from the certified nurse aides because Resident #1 did not report the allegation to them. The Director of Nursing #1 stated if there is a suspicion or allegation of abuse, the staff informs them immediately, and they start the process and gather statements. The Director of Nursing #1 stated statements are obtained from the staff (by the nursing supervisor if they were in the facility), the residents, and notification is made to the family and evaluate the resident. The Director of Nursing #1 stated their investigation conclusion was based on the findings and the interviews obtained. The Director of Nursing #1 stated the incident reported on 9/8/2024 was concluded as undetermined because Resident #2 denied the allegation and Resident #1 reported the allegation, but the story was inconsistent. The Director of Nursing #1 stated Resident #2 had never displayed the type of behavior before. Resident #2 and Resident #1 were roommates for a while and had never had any issues prior. The Director of Nursing #1 stated the Physician's Assistant assessed Resident #1 and there were no injuries. The Director of Nursing #1 stated the Medical Director is in the facility at least 2-3 times/week and as needed and the unsigned investigative summary might have been an oversight. The reports will be forward to the Medical Director for signature. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #3 was admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Muscle Weakness and Diabetes Mellitus. A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment and exhibited wandering behaviors. The resident used a wheelchair and a walker for locomotion. The resident required set up assistance with eating, supervision with toileting, bed mobility and transfers. Review of the facility investigative summary that is unsigned and undated documented that on 8/22/2024 at around 1:30 PM, an incident occurred involving Resident #2 and Resident #3. The Director of Nursing was informed by Licensed Practical Nurse #2 that Resident #2 hit Resident #3 on the head. Certified Nurse Aide #1 and Certified Nurse Aide #2 witnessed the incident, and reported that Resident #2, who was wheeling their self behind Resident #3, verbally expressing frustration by stating Resident #3 took their blanket. Subsequently, Resident #2 used a little flexi-bar (a rubber device from physical therapy) to strike Resident #3 from behind. Certified Nurse Aide #1 and Certified Nurse Aide #2 were present in the hallway and intervened immediately and prompted Resident #3 to return the blanket to Resident #2, which they did. The investigative conclusion documented Resident #3 was moved to another room and Resident #2 was transferred to the hospital for a psychological evaluation. It was concluded that Resident #3's severe cognitive impairment affected their memory, behavior and mobility and made it challenging for them to navigate the facility correctly and locate their room, leading to them entering Resident #2's room. Staff to continue to routinely check the hallway to redirect and prevent residents from wandering and entering other residents' rooms and intervene when needed to redirect residents with behavioral episodes and prevent any altercation. The investigation revealed that there was no evidence that any alleged abuse had occurred. During an interview on 3/10/2025 at 12:20 PM, Certified Nurse Aide #1 stated that on 8/22/2024 while sitting at the nurse's station on the 3rd floor, they heard loud speaking, and they went to where the noise was and saw Resident #2 and Resident #3. Certified Nurse Aide #1 stated Resident #2 was behind Resident #3, and they then tapped Resident #3 on the back of the head with a (Flexi-bar) rubber cylinder used in therapy. Certified Nurse Aide #1 stated they went behind Resident #2 and took the cylinder and asked what was going on. Certified Nurse Aide #1 stated Resident #2 was upset and stated Resident #3 who was confused had gone into their room by accident, but that it kept happening. Certified Nurse Aide #1 stated Resident #3 had a room change and they were confused and would forget where their room was located. Certified Nurse Aide #1 stated they separated Resident #2 and Resident #3 and reported the incident to the nurse. Certified Nurse Aide #1 stated they were the only witness who saw Resident #2 tap Resident #3 on the back of the head. Another certified nurse aide showed up by the time they got to the residents to separate them. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/13/2025 at 11:19 AM, the Director of Nursing #1 stated they determined no abuse occurred for the incident that occurred on 8/22/2024 because they had spoken with Resident #2, and they stated they were playing with Resident #3 when they hit them on the back of the head. The Director of Nursing #1 stated they assessed Resident #3, and there were no injuries. The Director of Nursing #1 stated the Certified Nurse Aide #1 reported that they saw Resident #2 coming towards the nursing station and Resident #3 had a blanket in their hand, Resident #2 had a Flexi-bar (rubber cylinder used in therapy) and took the Flexi-bar and tapped Resident #3 on top of the head. The Director of Nursing #1 stated Resident #2 knew what they were doing, and they were not trying to intentionally hurt Resident #3. Resident #2 was laughing the entire time and thought the action was funny, but Resident #2 has psychiatric issues. The Director of Nursing #1 stated the investigative summary not signed by any member of the medical team was an oversight and that they usually discuss these matters with the Medical Director. The Director of Nursing #1 stated Resident #2 obtained the Flexi-bar from the rehabilitation gym they use it for their exercise on the unit. During an interview on 3/13/2025 at 1:50 PM, the Administrator stated for investigations a statement is obtained from all witnesses, staff that were involved and other residents. The Administrator stated the staff that are assigned to the residents are interviewed, but it also depends on the type of allegation. The Administrator stated statements are obtained by the social worker or nursing for investigations. The Administrator stated they always review the investigation and the investigative summary with the Director of Nursing, and they are also involved in the reporting process to the Department of Health, notifying law enforcement, ensuring an investigation summary is completed and that all staff are completing their portions of the investigation. The Administrator stated they are responsible to sign off on investigations and the Medical Director is usually in the facility at least once a week as well as on weekend and as needed when called. 4) Resident #38 was admitted to the facility on [DATE] with diagnosis that include but not limited to Hypertension, Muscle Weakness, and cellulitis of the left lower limb. An admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Score of 15 indicating intact cognition, and resident had no behaviors, was independent with care and mobility. Resident had impairment to their lower extremity, uses a walker and wheelchair and was occasionally incontinent of bowel and bladder. Review of an abuse care plan dated 1/18/2024 documented the resident was at risk for being a victim of abuse due to inability to understand their surroundings, dependence on others for Activities of daily living and pain. Interventions included Investigate all allegations of abuse/ neglect promptly, help with activities of daily living as needed and Report to Provider and initiate assessment. Review of the daily staffing schedule from 1/29/2024 through 1/31/2024 revealed that statements were not obtained from all staff that worked on the first-floor unit. The facility incident report conclusion dated 2/8/2024 documented that although the Resident #38 alleged that cash in the amount of $33.00 dollars was taken and credit cards were used without consent, exploitation / misappropriation by a staff member is inconclusive at this time and there are no photographic or physical evidence to support the allegation that the perpetrator is a staff member. 5) Resident # 39 was admitted to the facility with diagnosis that included but not limited to Muscle weakness, Difficulty in Walking, and Obstructive Sleep Apnea. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of witness statements dated 2/1/2024 revealed that not all staff assigned to the first-floor unit on 2/1/2024 wrote a statement. Review of the incident report conclusion dated 2/8/2024 documented that although Resident #39 alleged that their credit card was used without their consent, exploitation/misappropriation by a staff member is inconclusive at this time as there are no photographic or physical evidence to support the allegation that the perpetrator is a staff member. 6) Resident # 40 was admitted to the facility diagnosis that included but not limited to Type 2 Diabetes, Weakness, and Difficulty in Walking. The admission Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview of Mental Status score 15 indicating intact cognition with no behaviors. Resident #40 required set up for eating, Partial/moderate assistance with bed mobility and transfers and was occasionally incontinent of bladder and always incontinent of bowel. Review of the incident report conclusion dated 2/8/2024 documented that although Resident #40 alleged that their credit card was used without their consent, exploitation/misappropriation by a staff member is inconclusive at this time as there are no photographic or physical evidence to support the allegation that the perpetrator is a staff member. A review of witness statements dated 2/1/2024 revealed that not all staff assigned to the first-floor unit on 2/1/2024 wrote a statement. A review of the police report number 24016061 dated 3/13/2024 documented Resident # 38, Resident # 39, and Resident # 40 reported missing property of credit and debit cards. Suspect unknown. The Summary documented Grand Larceny 3rd- 403 sector. Incident Report Narrative documented it should be noted that the Facility staff was present in each of the victim's rooms and offered to supply a lock and key for the top drawer of each of their nightstands. Previously the victims had no way to secure their belongings. Financial Crimes Detective notified. During an interview on 3/13/2025 at 1:50 PM, the Administrator stated the process of their investigations is to obtain a statement from witnesses, staff that were involved and any other residents. The Administrator stated the staff that are assigned to the residents are interviewed, but it also depends on the type of allegation. The Administrator stated the statements are obtained by the social worker or nursing for the investigations. The Administrator stated they and the Director of Nursing always review the investigation and the investigative summary and close the cases out. The Administrator stated they are involved in the reporting to the Department of Health, notifying law enforcement, ensuring an investigation summary is completed and ensuring all staff are completing their parts of the investigation. The Administrator stated they are responsible to sign off on the investigation. 10 NYCRR 415.4 (b)(1)(ii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00331567), the facility did not ensure the accuracy of resident's assessments for 1 out of 3 residents (Resident #4) reviewed. Specifically, Resident #4 was admitted to the facility on [DATE] with a documented history of wandering but was not identified as at risk for elopement by the facility on admission. Resident #4 was placed in a room on the first floor of the facility and on 1/14/2024, the resident exited the facility front doors unescorted after they were buzzed out by the Receptionist. The findings are: The undated facility admission Assessment and Follow Up: Role of the Nurse policy documented the purpose of the procedure is to gather information about the resident's physical, emotional, cognitive and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and comprehensive required assessment instruments. Conduct an admission assessment (history and physical) including a summary of the individual's recent medical history, including hospitalizations, acute illnesses and overall status prior to admission. Resident #4 admitted to the facility with diagnoses including but not limited to Muscle Weakness, Dementia and Generalized Anxiety Disorder. An admission Minimum Data Set, dated [DATE] documented Resident #4 had severe cognitive impairment with no behaviors noted. Resident #4 was ambulatory with impairment to both sides of their upper extremities and impairment to one side of their lower extremity. The resident required supervision with eating, moderate assistance with toileting, bed mobility and transfers and had no wander guard in use. Resident # 4's elopement risk score was a 5 denoting low risk and the resident was placed in a room on the first floor. Review of Resident #4's admission assessment dated [DATE] documented under elopement risk that the resident was disoriented and had not attempted to leave the facility or prior residence and does not wander. Review of the hospital history and physical dated 12/22/2023 and the hospital Discharge summary dated [DATE] documented Resident #4 had a history of Dementia, hypertension, hyperlipidemia, diabetes mellitus and prior transient ischemic attack, lived at home with their spouse, and per their family representatives had not been eating, was wandering outside, had been getting aggressive with family at times. During an interview on 3/13/2025 at 1:02 PM, the Admissions Director stated residents' medical history and physicals are received by them prior to the resident's admission. The Admissions Director stated the admission packet is reviewed by nursing, the physician and them. The Admissions Director stated they are responsible to review the resident's initial history and physical from the hospital. The Admissions Director stated a packet is printed and uploaded into point click care (the electronic medical record system) once the resident is scheduled to come to the facility for admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2025 at 3:17 PM, the Director of Nursing #1 stated they were not working at the facility when the incident occurred. The process is when a resident is admitted , an initial assessment is completed. During the assessment if the resident triggers as a risk for elopement by scoring above a 9(denotes high risk), a wander guard would be applied. The Director of Nursing #1 stated if a resident wanders or has the possibility of eloping, they will avoid placing the resident on the lower unit. During telephone interview on 4/15/2025 at 11:15 AM, the Director of Nursing #2 stated they did Resident #4's assessment on admission and would have reviewed the hospital record information during the admission assessment, but they do not recall seeing any information regarding the wandering in the documentation. The Director of Nursing #2 stated if wandering was noted in the hospital documentation, then Resident #4 would have been documented as an elopement and wandering risk and would have had a wander guard in place. 10 NYCRR 415.11(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and interview during an abbreviated survey (NY00331567), the facility did not ensure a comprehensive patient centered care plan was developed for 1 out of 3 residents reviewed for care planning. Specifically, Resident #4 was admitted to the facility on [DATE] and had a documented history of wandering. Resident #1 exited the facility through the front doors unescorted on 1/14/2024, after being buzzed out by the Receptionist. Review of Resident #4's care plan revealed they did not have a wandering or potential for elopement care plan in place. The Findings are: The facility Care Plans, Comprehensive Person-Centered policy last revised March 2022 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The comprehensive, person-centered care plan includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Resident #4 was admitted to the facility on [DATE] with diagnoses including but not limited to Muscle Weakness, Dementia and Generalized Anxiety Disorder. An admission Minimum Data Set, dated [DATE] documented Resident #4 had severe cognitive impairment with no behaviors noted. Resident #4 was ambulatory with impairment to both sides of their upper extremities and impairment to one side of their lower extremity. The resident required supervision with eating, moderate assistance with toileting, bed mobility and transfers and had no wander guard in use. Review of the hospital history and physical dated 12/22/2023 and the hospital Discharge summary dated [DATE] documented Resident #4 had a history of Dementia, Hypertension, Hyperlipidemia, Diabetes Mellitus and prior Transient Ischemic Attack. Resident #4 lived at home with their spouse, and per their family representatives had not been eating, was wandering outside and had been getting aggressive with family at times. Review of an impaired cognition care plan initiated 12/28/2023 documented Resident #4 had impaired thought processes related to Dementia. Interventions listed included keep the resident's routine consistent and as much as possible provide consistent care givers as much as possible in order to decrease confusion and monitor/document/report to physician any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a forgetfulness/confusion last revised 1/10/2024 documented Resident #4 requires reminders to participate in leisure activities. Interventions listed included invite/escort to group/strolling activities and provide 1:1 recreation session as able. There was no documented evidence of a wandering or elopement risk care plan being implemented for Resident #4. During telephone interview on 4/15/2025 at 11 :15 AM, the Director of Nursing #2 stated they did Resident #4's assessment on admission and there was no wandering or exit seeking observed for Resident #4 while in the facility. The Director of Nursing #2 stated Resident #4's hospital record would have come over to the facility for review and they would review this information during the admission assessment, but they do not recall seeing any information regarding the wandering in the documentation. The Director of Nursing #2 stated the elopement risk and the wandering care plans were not initiated for Resident #4 because they did not see any information regarding wandering on their hospital documentation. The Director of Nursing #2 stated if wandering was noted in the documentation, then they would have initiated these care plans. 10 NYCRR 415.11(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00331567), the facility did not ensure that the resident environment remained free of accident hazards and that each resident received adequate supervision for 1 out of 3 residents (Resident #4) reviewed for elopement. Specifically, on 1/14/2024 Resident #4 exited through the front doors of the facility unescorted, after being buzzed out by the Receptionist at 3:33 PM. Resident #4 with a documented history of wandering, was assigned a room on the first floor of the facility. Resident #4 exited the facility and wandered into a neighboring home near the facility and the neighbor called 911. The facility was notified of Resident #4's whereabouts around 4:31 PM by emergency medical services after the resident was transferred to the hospital. The Findings are: The Facility Elopement policy last revised 7/2024 documented when a resident is reported missing, the following action plan will be initiated to conduct a prompt, thorough search to locate the resident and provide a safe return to their unit. An elopement risk evaluation is done on admission, quarterly and as needed. The plan of care is established based on evaluation for each resident if needed. In the event a resident is regarded as risk for elopement a wander guard is applied to the resident. A picture of the resident is placed at the nurse's station and at a front desk and the interdisciplinary team is notified. Resident #4 was admitted to the facility with diagnoses including but not limited to Muscle Weakness, Dementia and Generalized Anxiety Disorder. An admission Minimum Data Set, dated [DATE] documented Resident #4 had severe cognitive impairment with no behaviors. Resident #4 was ambulatory with impairment to both their upper extremities and impairment to one side of their lower extremity. The resident required supervision with eating, moderate assistance with toileting, bed mobility and transfers and had no wander guard in use. Review of the hospital history and physical dated 12/22/2023 and the hospital Discharge summary dated [DATE] documented Resident #4 had a history of Dementia, Hypertension, Hyperlipidemia, Diabetes Mellitus and prior Transient Ischemic Attack. Resident #4 lived at home with their spouse, and per their family representatives had not been eating, was wandering outside and had been getting aggressive with family at times. Review of Resident #4's admission assessment dated [DATE] documented on the elopement risk column that the resident was disoriented, had not attempted to leave the facility or prior residence, and does not wander. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the investigative summary documented on 1/14/2024 at 3:33 PM Resident #4 left the facility dressed in weather appropriate clothing, wearing a brown colored coat. Resident #4 spent most of the previous shift in their room and at 3:33 PM exited the facility and shortly afterwards entered the yard of a nearby home. At approximately 4:21 PM, the staff observed during rounds that Resident #4 was not in their room and immediate search for the resident was started in Resident #4's room and the other rooms/bathrooms on the assigned unit as well as other floors. At approximately 4:31 PM, while the search was still in progress emergency medical services arrived at the facility and informed the staff that Resident #4 was taken to the hospital emergency room for evaluation. The immediate action taken documented all visitors and vendors to the facility are now required to sign in and out when leaving the facility. The investigative conclusion dated 1/14/2024 concluded that Resident #4 left the facility unescorted and was located shortly within close proximity to the facility. The investigation revealed that there is no evidence to support that any alleged resident Abuse, Neglect or Mistreatment may have occurred. During an interview on 3/10/2025 at 9:35 AM, the Director of Nursing stated elopement assessments are completed on admission, quarterly and as needed by the unit nurses. During an interview on 3/10/2025 at 1:37 PM, the Director of Nursing stated they do use wander guards in the facility. The Director of Nursing stated residents that are elopement risks or have wander guards in place are preferably not placed on the first floor, and all units are alarmed for the wander guards. During a telephone interview on 3/13/2025 at 12:35 PM, the Receptionist stated they arrived at the facility for their shift on 1/14/2024 and they were not aware that Resident was a new resident in the facility at the time. The Receptionist stated Resident #4 was dressed casually like a civilian, and they did not notice any medical bands on the resident, so they opened the door and let the resident out of the facility. The Receptionist stated some visitors are not very talkative and are focused in getting where they are going, so they did not pay attention and let the resident out based on experience from regular visitors. The Receptionist stated two hours later the emergency medical services arrived and informed them they had located a resident from the facility outside and had taken them to the hospital to be evaluated, but they did not know what resident they were talking about, because they were not aware Resident #4 was a resident of the facility. The Receptionist stated the emergency medical service team then went to the nurse's station and began asking the nurses questions. The Receptionist stated they then went over to the nurse's station to see what the commotion was about. The Receptionist stated they asked why Resident #4 did not have a wander guard on. The Receptionist stated Resident #4 was also not on an elopement risk list kept at the front desk and the nurses stated they did not know that the resident would be wandering. The Receptionist stated when Resident #4 returned to the facility they were moved to the second floor. The Receptionist stated Resident #4 did not have an identification band on and when the nurse and the emergency medical services spoke with Resident #4's spouse they revealed Resident #4 had planned this ahead of time. During an interview on 3/13/2025 at 1:02 PM, the admission Director stated they could not recall why Resident #4 was placed on the first floor, but it was likely because they were told that the wandering risk had been stopped for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2025 at 1:50 PM, the Administrator stated the incident that occurred on 1/14/2024 was handled by them and Director of Nursing #2. The Administrator stated a resident's final approval for admission to the facility is signed off by the Director of Nursing. The Administrator stated they are responsible for conducting some in-services, such as customer service and new regulation training alongside with nursing. The Administrator stated their target audience for their in-service regarding the 1/14/2024 incident was the front desk staff and now they have a tighter front desk protocol in the facility. During an interview on 3/13/2025 at 3:17 PM, the Director of Nursing #1 stated they were not the Director of Nursing at the time of the incident on 1/14/2024. The Director of Nursing #1 stated when a resident is admitted an initial assessment is completed and if the elopement score is high, then a wander guard is applied. The Director of Nursing stated if the resident does not trigger on the elopement assessment and during their stay, they exhibit wandering behavior, another assessment is completed, and a wander guard is applied. The Director of Nursing #1 stated the criteria for applying the wander guard is based on the elopement assessment score. The score determines if a wander guard is needed or not. The Director of Nursing #1 stated if a resident has a possibility of wandering or eloping, they will avoid placing the resident on the lower unit. During telephone interview on 4/15/2025 at 11:15 AM, the Director of Nursing #2 stated they remember the elopement incident that occurred on 1/14/2024 with Resident #4. The Director of Nursing #2 stated they received a phone call from the facility staff that Resident #4 left the building, and that the Receptionist thought the resident was a visitor and buzzed them out. The Director of Nursing #2 stated once they were informed about the incident, they called the Administrator to inform them. The incident occurred close to the change of the shift. The Director of Nursing #2 stated Resident #4's room was located on the first floor across from the nurse's station and there was no wandering or exit seeking observed while in the facility otherwise the resident would have had a wander guard in place. 10 NYCRR 415.12(h)(1)