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	08/14/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00338972) survey from 8/6/2024 to 8/14/2024, the facility did not ensure prompt resolution of a resident's grievance and did not establish a grievance policy including all necessary elements. that includes notifying residents of their right to file a grievance . This was evident for 1 (Resident #10) of 25 total sampled residents. Specifically, 1) the facility Grievance Policy did not include the method used to notify residents of the grievance process and the resident's right to obtain the decision in writing, 2) Resident #10's Designated Representative reported the resident was missing clothing and glasses and was not provided with a prompt resolution. The findings are: The facility policy titled Investigations of Grievances/Concerns dated 6/13/2024 documented a thorough investigation of all grievances will be completed, and the resident or resident representative will be informed of the findings of the investigation. There was no documented evidence the facility Grievance Policy identified whether residents were informed of the grievance process individually or with prominent postings throughout the facility. The Grievance Policy did not document the resident's or resident representative's right to obtain a copy of the grievance review in writing. Resident #10 had diagnoses of schizoaffective disorder, bipolar disorder, catatonia, and major depressive disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #10 was severely cognitively impaired. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 at 10:13 AM, Resident #10's Designated Representative was interviewed and stated Resident #10 had missing clothing since their hospitalization in 10/2023. The Designated Representative stated staff assured them Resident #10's clothing would be kept in storage until they returned from the hospital. Resident #10 returned from the hospital in 1/2024 and the Designated Representative stated they spoke with the Director of Social Work several times since then to complain about missing clothing. The Designated Representative stated the Director of Social Work told them they needed to provide copies of the Resident's #10's clothing inventory sheet. The Designated Representative faxed a list of missing items to the Director of Social Work in April 2024, discussed the missing clothing and glasses in a care plan meeting held with the Director of Social Work on 4/12/2024, and has not received a resolution. The Designated Representative stated they were not offered the opportunity to file an official grievance or receive the grievance review and resolution in writing. Social Work Note dated 4/18/2024 documented a care plan meeting was held with the Designated Representative and Ombudsman on 4/12/2024. On 8/8/2024, the grievances for 8/2023 through 8/2024 were requested from the Social Work Department. After reviewing the grievances provided, there was no documented evidence the missing clothing and glasses complaint by Resident #10's Designated Representative was investigated. On 08/14/2024 at 02:32 PM, and 3:28 PM, the Director of Social Work was interviewed and stated they recall Resident #10's Designated Representative reporting missing clothing after they went to the laundry. Staff found the clothing and the issue was resolved so no grievance investigation was necessary. If the clothing was not found, the Director of Social Work would conduct a grievance investigation and the resident or representative would be reimbursed. Grievances were resolved within 1 to 2 weeks of being reported. Once resolved, the Administrator signs the grievance form, and the Director of Social Work calls the family to inform them of the outcome. The residents or representatives were not provided with a written copy of the grievance report unless they asked for a copy. On 08/14/2024 at 06:13 PM, the Administrator was interviewed and stated they were present at the care plan meeting with Resident #10's Designated Representative and the Director of Social Work in 4/2024. The Administrator did not recall whether Resident #10's Designated Representative reported missing clothing and glasses during the care plan meeting. The Social Work Department was responsible for filing grievances. They investigate, made a determination, and wrote conclusions. The Administrator stated the Social Work Department would have to be asked about how they inform residents and families of grievance investigation outcomes. On 8/14/2024 at 7:30 PM, the Director of Social Work stated they found a grievance for Resident #10 and provided a copy of the Complaint/Grievance Form for Resident #10 dated 4/11/2024. The Complaint/Grievance Form documented a completion date of 4/17/2024. The facility had no record of the items reported missing and the Designated Representative would pick up a copy of the form upon their next visit. 10 NYCRR 415.3(d)(1)(ii)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00338972) survey from 8/6/2024 to 8/14/2024, the facility did not ensure an effective discharge planning process was developed and implemented focused on the resident's discharge goals, involved the resident and resident representative, and was updated. This was evident for 1 (Resident #10) of 25 total sampled residents. Specifically, upon return from the hospital and without the Designated Representative's involvement, Resident #10 was issued a Discharge Notice listing the destination as a skilled nursing facility that was not suitable for the resident's needs. The findings are: Resident #10 had diagnoses of schizoaffective disorder, bipolar disorder, catatonia, and major depressive disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #10 was moderately cognitively impaired, did not display mood symptoms, and was physically aggressive towards others. On 08/07/2024 at 04:55 PM, the Ombudsman was interviewed and stated they were part of care plan meetings with Resident #10, the Designated Representative, the Director of Social Work, and the Administrator related to issuance of a Transfer/Discharge Notice to Resident #10 in 4/2024. The Designated Representative contacted the Ombudsman because the facility refused to accept Resident #10 back from the psychiatric hospital. The facility eventually agreed to Resident #10's return but issued a Transfer/Discharge Notice the day after the resident was readmitted . The reason given for transfer was Resident #10 required a facility with a specialized psychiatric unit. The facility listed on the Notice was contacted by the Ombudsman and was found to have no specialized psychiatric treatment or unit suitable for Resident #10's needs. The Ombudsman found several Notices were issued to residents for transfers to other facilities. The Ombudsman met with the Administrator and Director of Social Work and discussed appropriate issuance of Transfer/Discharge Notices in accordance with resident rights. On 08/08/2024 at 10:13 AM, the Designated Representative was interviewed and stated they became aware the facility did not want to accept Resident #10 for readmission to the facility during the resident's psychiatric hospitalization in 3/2024. They had discussions with the facility staff and was told Resident #10 would only be readmitted for 1 day and then was going to be transferred to another facility with a specialized psychiatric unit. The Designated Representative was informed verbally of the Transfer/Discharge Notice and conferred with the Ombudsman who discovered the prospective facility listed on the Notice did not have a specialized psychiatric unit or services for Resident #10. The facility verbally informed the Designated Representative the Transfer/Discharge Notice had been rescinded and had a care plan meeting to discuss alternate placement. The Preadmission Screening and Resident Review Level II Outcome Form dated 9/14/2023 documented Resident #10 had a serious mental illness and required a person-centered psychiatric care plan. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to discharge planning initiated 2/1/2024 and last revised 2/6/2024 documented Resident #10's placement was long-term. Interventions included encouraging Resident #10 to discuss their feelings about long-term placement and evaluating and discussing the prognosis for independent living with the resident and Designated Representative. Social Work Note dated 3/1/2024 documented Resident #10 was not accepted for transfer to 2 facilities closer to the Designated Representative's location. Physician Assistant Note dated 3/8/2024 documented Resident #10 was transferred to the hospital for psychiatric evaluation. The Nursing Admission Evaluation dated 4/3/2024 documented Resident #10 was readmitted from the hospital and did not display delusions, hallucinations, or behaviors. Social Work Note dated 4/4/2024 documented Resident #10 was readmitted , and a care plan meeting was scheduled for 4/12/2024 with the Designated representative to discuss discharge planning. The Transfer/Discharge Notice dated 4/5/2024, signed by the Administrator, documented Resident #10 was scheduled for discharge to another facility on 5/6/2024. Resident 10's needs could not be met as evidenced by a medical professional's recommendation for a specialty psychiatric unit and the safety of the individuals in the facility would be endangered as evidenced by staff being hit and bitten by Resident #10 prior to psychiatric hospitalization . Resident #10 was unable to sign the Notice and the Designated Representative was notified over the phone. There was no documented evidence the Transfer/Discharge Notice contained the contact information for the agency responsible for the protection and advocacy of individuals with a mental disorder under the Protection and Advocacy for Mentally Ill Individuals Act. Social Work Note dated 4/15/2024 documented the Director of Social Work referred Resident #10 to 7 different facilities and notified the Ombudsman and Designated Representative. Social Work Note dated 4/18/2024 documented a care plan meeting was held with the Designated Representative and Ombudsman on 4/12/2024. The Designated Representative expressed a desire for Resident #10 to be transferred to a facility closer to where they live and emailed a list of facilities to the Director of Social Work. Social Work Notes dated 4/18/2024, 4/25/2024, and 4/26/2024 documented follow up regarding Resident #10's referrals to other facilities. The Social Service Evaluation dated 5/13/2024 documented Resident #10 was long-term, and the goal was for the resident to remain in the facility. Social Work Note dated 5/17/2024 documented follow up with alternate facilities Resident #10 was referred to for admission. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence Resident #10 and Designated Representative were issued involved in the decision to refer Resident #10 to the facility listed in the Transfer/Discharge Notice dated 4/5/2024. There was no documented evidence the Transfer/Discharge Notice was adequate and included contact information for the designated advocacy agency for persons with mental illness. There was no documented evidence Resident #10's discharge care plan was reviewed and revised with developments and changes including the issuance of a Transfer/Discharge Notice and whether the Notice was rescinded or revised. On 08/14/2024 at 02:32 PM and 03:28 PM, the Director of Social Work was interviewed and stated the Administrator was responsible for determining which residents received Transfer/Discharge Notices. The Social Work Department was responsible for discharge planning and the Director of Social Work stated as long as they have allocation for a residency, they can issue a Transfer/Discharge Notice. The residents had the right to appeal. The interdisciplinary team and the Administrator meet and discuss the best discharge destination for a resident prior to issuing the Notice. If there are financial concerns, the resident ss where is the best place to send a resident. If a resident had financial issues, the facility transferred them to another facility. The Administrator informed the Director of Social Work that they knew of a facility with specialized psychiatric services and instructed the Director of Social Work to refer Resident #10 to the other facility for admission. The other facility accepted Resident #10 for admission and the Director of Social Work issued the Transfer/Discharge Notice to the Designated Representative. The Director of Social Work stated Resident #10 has been designated as a long-term resident because of their need for skilled nursing services. Even if Resident #10 was discharged to another facility, it would be a long-term care facility. The Director of Social Work was still applying for Resident #10 to be transferred to other facilities, but no one have accepted the resident for admission. The Director of Social Work wrote a note re: issuance of the Transfer/Discharge Notice to Resident #10 but deleted the note after the Notice was rescinded. The Director of Social Work did not document the Ombudsman and Designated Representative discussions or interactions related to the issuance of the Notice. On 08/14/2024 at 06:13 PM, the Administrator was interviewed and stated they issued Transfer/Discharge Notices to residents who were a danger to themselves or others, no longer required skilled level of care, or non-payment. Resident #10 received a Notice due to their unmanageable behaviors and multiple psychiatric hospitalization s since they became a resident of the facility. The facility had no choice and was required to readmit Resident #10 from the psychiatric hospital on 4/4/2024. The Administrator stated they believed the Transfer/Discharge Notice was issued to Resident #10 a few weeks after they returned from the hospital. They discussed alternative placement for Resident #10 closer to the Designated Representative. Attempts were made to find a facility with specialized psychiatric services. The facility listed on the Notice claimed to have such a unit, but the Ombudsman found out there was not specialized psychiatric unit at the proposed facility. The Administrator stated the Designated Representative was informed facility cannot adequately accommodate Resident #10's behaviors. Staff have not and mentioned that we would not be able to adequately accommodate the resident's behaviors. 10 NYCRR 415.11(d)(1)(2)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, record review, and interviews during the Recertification survey the facility did not ensure that each resident in need of assistance, to carry out activities of daily living, received the necessary services in a timely manner for 1 of 5 residents reviewed for Activities of Daily Living. Specifically, Resident #95 was not provided incontinence care as need or as scheduled. Findings include: Resident #95 had diagnoses including urinary tract infection, paraplegia, and respiratory failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident was cognitively intact, and dependent on staff for transfer, ambulation, toilet use and personal hygiene. Resident #95 was frequently incontinent bowel and bladder. The grievance form dated 7/8/24 documented Resident #95 wanted their adult brief changed more often. The documented resolution was for Resident #95 to be changed every 2 hours and as needed when soiled. The nursing note dated 8/6/24 at 7:56 AM, documented the resident complained of burning and urgency upon urination; the physician was notified. The nursing note dated 8/6/24 at 4:54 PM, documented urine sample obtained via straight catheter with no pain or discomfort. The physician note dated 8/6/24 documented they educated the resident on hydration-refusing intravenous fluids at this time, educated patient on Pyridium for symptomatic relief-refusing at this time, obtain urine analysis and labs, would start on antibiotic if needed, discussed with patient, nursing aware. On 8/06/24 at 10:28 AM, Designated Representative #1 stated that Resident #95 waited 12 hours on Sunday (8/4/24) and 9 hours on Monday (8/5/24) to be changed with a dirty adult brief. As Designated Representative #1 explained to the surveyor that the resident could not feel when they were soiled, they checked the resident's brief and stated it was soiled. Designated Representative #1 stated the resident often got urinary tract infections often and became septic, they were trying to prevent the resident from getting septic. On 8/09/24 at 10:15 AM, Resident #95 stated they were waiting for someone to change them, and the results of urine test was positive for a urinary tract infection. On 8/09/24 at 12:38 PM, Resident #95 stated they still had not been changed. Designated Representative #1 arrived and stated they went to nurse to find out why resident had not been changed. Resident #95 stated they were last changed at 5:00 AM. While in resident's room the certified nurse aide came into room to provide care and Designated Representative #1 stated the resident was care planned to be out of bed by 10 AM to be ready for rehab therapy. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/24 05:04 PM, Licensed Practical Nurse #11 stated the resident sometimes refused to get out of bed and staff would come back later to get them up. Practical Nurse #11 stated they did not document the refusals to get out of bed. Licensed Practical Nurse #11 stated they did not know why Resident #95 waited until 12:38 PM on 8/9/24 to receive incontinence care. Licensed Practical Nurse #11 stated the aides usually checked on the resident at 10:30 AM to see if they wanted to get up. Licensed Practical Nurse #11 stated they were not sure if there was a care plan that documented the resident preferred time to get out of bed. On 8/14/24 at 5:52 PM, Director of Nursing stated there was no reason for the resident to wait until 12:38 PM to be changed and stated the resident should be changed every 2 hours. Director of Nursing was unable to provide documented evidence that the resident was changed every 2 hours. 415.12(a)(2)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50816 Based on observation, interview, and record review conducted during the Recertification Survey and Abbreviated survey (NY00341698) on 8/6/2024 to 8/14/2024, the facility did not ensure the necessary treatment and services, consistent with professional standards of practice, were provided to an existing pressure injury for 1 of 2 residents (Resident # 81) reviewed for pressure ulcer. Specifically Resident #81 was found with a skin opening on the sacrum on 8/1/2024 and a registered nurse did not assess the area or notify the physician until the following day. Findings include: The facility Policy on Pressure Injury Risk and Assessment, dated 5/24, documented information should be recorded in the resident's medical record to include any change in the resident's condition if identified, the condition of the skin if identified, initiation of a pressure or non-pressure form related to the type of alteration in skin if new skin alteration noted, documentation addressing MD notification if new skin alteration is noted. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition. The interventions must be based on current, recognized standards of care. The effects of the interventions must be evaluated. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate. Resident # 81 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, major depressive disorder, mood disorder and anxiety. The Significant Change Minimum Data Set (MDS; a resident assessment tool) dated 7/26/2024 documented the resident had had severe cognitive impairment, was at high risk for developing pressure ulcers, was always incontinent of urine and bladder, and had no pressure ulcer. The care plan dated 11/2023 for the resident was at risk of skin breakdown. Interventions included a wheelchair cushion, turning and positioning, incontinent care, dietary and nutrition interventions, laboratory monitoring, weight monitoring and weekly skin checks. The 8/1/24 at 7:36 PM Licensed Practical Nurse #12 progress note documented the resident had a partial skin loss on the sacrum, the Registered Nurse Supervisor was notified, and a protection barrier was applied. The 8/2/2024 at 4:44 PM Licensed Practical Nurse # 11 progress note documented that the Certified Nurse Aide called them during morning care to check on the resident. The resident had a dressing on their sacral area which was not there yesterday. Skin evaluation done, noted with open area on sacrum approximately 1. 7-centimeter x 1.3 centimeter x 0.1 centimeter, peri wound (surrounding skin) clean, dry and intact. The 8/2/2024 at 4:44 PM Director of Nursing Pressure Injury Investigation and Audit Form documented pressure injury onset 8/1/2024, Sacrum pressure ulcer Stage 2 measured 1.7 centimeters in length, 1.3 centimeters in width and 0.1 centimeter in depth, no exudate. The family and physician were notified on 8/2/2024 and the care plan was revised. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/2/24 Physician Assistant progress note documented the resident was seen per nurse request for skin opening on sacrum. Reports no pain on sacrum and apply collagen powder to site status post cleanse with normal saline follow up wound team, positional changes per facility protocol, and supplements. 8/3/2024 Physician's Orders documented skin opening sacrum stage 2 - apply collagen powder and cover with dry protective dressing. On 8/12/24 at 10:11 AM the resident was observed during wound rounds with Licensed Practical Nurse #11 and the wound care consultant. The resident was lying in bed, on her back, assisted to left side by Licensed Practical Nurse #11 and wound care consultant. Sacrum wound was measured by wound consultant and treatment was done by Licensed Practical Nurse #11. The wound measured 2 centimeters in length, 0.5 centimeters in width, 0.1 centimeters in depth. In an interview on 8/12/24 at 5:20 PM, Registered Nurse #15 they stated they worked on 8/1/2024 evening shift and were not informed that Resident #81 had an open area on the sacrum. In an interview on 8/13/24 at 3:39 PM, Licensed Practical Nurse #11 stated that on 8/2/24 Certified Nurse Aide #4 told them about resident's opening on the sacrum. Licensed Practical Nurse #11 stated they checked and found a dry protective dressing on the sacrum and removed it. Licensed Practical Nurse #11 stated they went to the morning meeting and discussed the open area that was observed. The Physician Assistant put in an order for treatment. During interviews on 8/12/24 at 11:32 AM and 8/13/24 at 4:07 PM, the Director of Nursing stated that when a resident developed a new pressure ulcer, the Registered Nurse would do the assessment and evaluation, and a new pressure ulcer nosocomial form would be completed. The Director of Nursing stated Registered Nurse Supervisor #15 should have assessed the pressure ulcer on 8/1/24 when it was found, and the physician should have been notified. The Director of Nursing stated they spoke to Registered Nurse Supervisor #15 on 8/2/24 and Registered Nurse Supervisor #15 said they did not assess or call the physician as they were unaware of the open area. 10 NYCRR 415.12(c)(1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00347185) surveys from 8/6/2024 to 8/13/2024, the facility did not ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was evident for 2 (Resident #88 and #213) of 3 residents reviewed for pain. Specifically, 1) Resident #88 was not administered pain medication in accordance with Physician's Orders, was not provided non-medication interventions to address pain, and had recommendations for pain management by a Physiatrist that were not reviewed by the Physician Assistant, and 2) Resident #213 was not administered pain medication in accordance with Physician's Orders. The findings are: The facility policy titled Pain Assessment and Management dated 6/2024 documented the medication administration record was reviewed to determine how often the individual requests and receives pain medication and the extent of pain relief. The comprehensive pain assessment gathers information from the resident including a history of non-pharmacological pain interventions. Implement the medication regimen as ordered. 1) Resident #88 had diagnoses of left above the knee amputation and neuropathy. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #88 was cognitively intact, received a pain medication regime, was not offered pain medication as needed, did not receive nonpharmacological interventions for pain, and experienced mild pain almost constantly. On 08/06/2024 at 12:41 PM, Resident #88 was interviewed and stated they recently had surgical amputation of their left leg above the knee and experienced persistent pain to the surgical site that was not relieved by their current pain medication. Resident #88 reported the pain to the Physician Assistant but there have not been any changes to their treatment plan. The Comprehensive Care Plan related to chronic pain initiated 3/24/2024 and last reviewed 7/30/2024 documented Resident #88 had neuropathy, potential phantom pain, and pain from recent surgery. Interventions included monitoring, recording, and reporting Resident #88's complaints of pain and requests for pain treatment and anticipating Resident #88's need for pain relief timely. Non-pharmacological interventions to address pain were not documented. The Physician Orders dated 4/11/2024 documented Resident #88 was ordered to receive Gabapentin 400 mg three times daily for neuropathic pain and monitoring of the resident's pain be done every shift using a pain scale of 1 to 10. The Physician Order dated 7/3/2024 to 7/23/2024 documented Resident #88 was ordered Oxycodone hydrochloride 5 milligrams every 8 hours as needed for pain. The Medication Administration Record dated 7/3/2024 to 7/23/2024 documented Resident #88 reported pain ranging from 0 to 10 on 16 out of 21 days and was administered Oxycodone Hydrochloride 27 times. The record documented the medication was effective each of the 27 times administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Assistant Note dated 7/10/2024 documented Resident #88 was evaluated and did not document an assessment of Resident #88's pain. A Physiatry Consult dated 7/12/2024 documented Resident #88 was evaluated due to amputation site pain and included a plan to consider increasing Gabapentin to 600 mg three times daily. An ultrasound and/or magnetic resonance imaging of Resident #88's left above the knee amputation stump was recommended to rule out neuroma. The Physician Orders dated 7/22/2024 to 7/31/2024 documented Resident #88 was ordered Oxycodone hydrochloride 5 milligrams every 8 hours as needed for pain. The Medication Administration Record from 7/22/2024 to 7/31/2024 documented Resident #88 reported pain ranging from 0 to 7 and was administered Oxycodone hydrochloride 5 milligrams 14 times on 9 out of 10 days. The record documented the medication was effective each of the 14 times administered. The Physician Assistant Note dated 7/24/2024 documented Resident #88 was evaluated but did not document an assessment of the resident's pain. The Nursing Pain Evaluation dated 7/30/2024 documented Resident #88 frequently experienced pain in the past 5 days that interfered with day-to-day activities. On a scale from 1 to 10, Resident #88 reported their pain was a 7. Resident #88 vocally complained of pain daily and did not receive non-medication intervention for their pain. The Physician Order dated 7/31/2024 to 8/2/2024 documented Resident #88 was ordered Oxycodone hydrochloride 5 milligrams every 8 hours as needed for 8 to 10 severity level of pain. The Medication Administration Record dated 7/31/2024 to 8/2/2024 documented Resident #88 was administered Oxycodone once on 7/31/2024 for a pain level of 0. On 8/1/2024, Resident #88 was administered Oxycodone once for a pain level of 7 and once for a pain level of 0. The Physician Assistant Note dated 8/1/2024 documented Resident #88 was evaluated and did not document an assessment of Resident #88's pain. The Physician Orders dated 8/2/2024 documented Resident #88 was ordered Oxycodone hydrochloride 5 milligrams every 8 hours as needed for a moderate pain level of 6 to 10 and Tylenol extra strength 1000 milligrams every 8 hours as needed for a mild to moderate pain level of 1 to 5. The Medication Administration Record for August 2024 documented Resident #88 was administered Oxycodone hydrochloride 5 milligrams for a pain level of 0 on 8/4, 8/5, and 8/11/2024, a pain level of 2 on 8/7/2024, a pain level of 3 on 8/2 and 8/6/2024. Tylenol extra strength 1000 milligrams was not administered to Resident #88. There was no documented evidence Resident #88 was administered pain medication in accordance with the Physician Order or received non-medication pain interventions to address their pain. There was no documented evidence the Physiatry Consult was reviewed, and recommendations addressed in relation to Resident #88's pain management plan of care. (continued on next page)

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/2024 at 10:05 AM, Licensed Practical Nurse #11 was interviewed and stated Resident #88 expressed a pain severity of 7 out of 10. Oxycodone hydrochloride 5 milligrams was administered to Resident #88 when they expressed pain and Licensed Practical Nurse #11 followed up with the resident an hour after medication administration to determine its efficacy. Most of the times, Resident #88 felt better after receiving their medication. Resident #88 was ordered to receive Tylenol extra strength 1000 milligrams if the Oxycodone was not effective. Resident #88 was not administered the Tylenol. After reviewing the medical record, Licensed Practical Nurse #11 stated the Physician's Order was for Resident #88 to receive the Tylenol for a pain level between 1 and 5 out of 10 and Oxycodone for a pain level of 6 to 10 out of 10. Ice packs were available as a non-pharmacological intervention for pain, but cold packs were not provided to Resident #88. The facility recently began consulting with a Physiatrist for pain management. Resident #88 was referred to the Physiatrist because the Oxycodone was not effective. Licensed Practical Nurse #11 stated they did not review the Physiatry Consults and the Physician Assistant was responsible for reviewing and ordering the Physiatrist's recommendations. The Physician Assistant evaluated Resident #88's pain management monthly. Licensed Practical Nurse #11 stated they would communicate with the Physician Assistant if a resident's pain management interventions were not effective, and they have had no communication with the Physician Assistant regarding Resident #88's pain. On 08/14/2024 at 09:46 AM, the Director of Rehabilitation was interviewed and stated the nurse, Physician Assistant, or Director of Rehabilitation could order a Physiatry Consult for pain management but could not recall who was responsible for referring Resident #88 to the Physiatrist. Resident #88 recently began complaining of a lot of pain and was provided with nerve stimulation during their physical therapy sessions. The Director of Rehabilitation stated they communicated to Nursing in the facility's morning report that Resident #88 was experiencing more pain. The Physician Assistant was responsible for reviewing and addressing the Physiatry Consult recommendations. On 08/14/2024 at 11:51 AM, the Physician Assistant was interviewed and stated Resident #88 was ordered Oxycodone and Tylenol for pain as needed. Resident #88 had a standing order for Gabapentin 400 milligrams 3 times daily for neuropathic pain. The Physician Assistant stated they assessed Resident #88's pain every time they visited the resident. Resident #88 did not report an increase in pain. The Physician Assistant did not assess Resident #88's pain level using a numeric pain scale and stated the resident did not report that their pain was excruciating. The Physician Assistant stated they do not review the pain scale documented by nursing in the resident's medical record unless the resident reported pain at the time of Physician Assistant's visit. The Physician Assistant stated they did not review the Nursing Pain Evaluation completed 7/30/2024 for Resident #88. After reviewing medical record, the Physician Assistant stated Resident #88 was evaluated by the Physiatrist on 7/12/2024 and an increase in Gabapentin, ultrasound, and magnetic electronic imaging were recommended. The Rehabilitation Department probably referred Resident #88 to the Physiatrist because the resident experienced pain during therapy. The Physician Assistant was unable to provide documented evidence the Physiatry Consult recommendations were reviewed. On 08/14/2024 at 06:00 PM, the Administrator was interviewed and stated they could not recall when the facility began consulting with a Physiatrist for pain management recommendations. Nursing and Rehabilitation staff referred residents to the Physiatrist and the Physiatry Consults were uploaded in the electronic medical record for the interdisciplinary team to review. The Physician Assistant or Medical Doctor were responsible for reviewing and determining whether to follow the Physiatrist's recommendations. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41666 2) Resident #213 was admitted on [DATE] with diagnoses of left shoulder replacement, renal insufficiency and obstructive uropathy. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #213 was cognitively intact, received a pain medication regimen, was offered as needed pain medications, was not provided non-pharmacological pain intervention, and occasionally experienced a pain severity of 4 out of 10 that affected their sleep, physical therapy, and day-to-day activities. The Comprehensive Care Plan related to pain dated 5/30/2024 documented Resident #213 will would be administered pain medications as ordered by the physician. The Physician's Order dated 6/620/24 documented orders for Resident #213 to receive Oxycodone Hydrochloride 5 milligrams every 6 hours for pain at 12 AM, 6 AM, 12 PM, and 6 PM. The Narcotics Log for June 2024 documented Resident #213's Oxycodone 5 milligrams was delivered from the pharmacy on 6/7/2024 and the last dose was given at 6/16/2024 at 6 AM. The Medication Administration Record for June 2024 documented Resident #213 was administered Oxycodone 5 milligrams on 6/16/2024 at 6 AM and 6 PM. Oxycodone was marled as unavailable on 6/16/2024 at 12 PM, 6/17/2023 at 12 AM, 6 AM, 6 PM, and 6/18/2024 at 12 AM. Nursing Note dated 6/16/2024 at 2:07 PM documented Resident #213 received Oxycodone wasted from another supply. At 6:00 PM the nurse documented Resident #213 was administered Oxycodone. On 6/17/2024 at 12 AM, the nurse documented they were awaiting pharmacy delivery of Resident #213's Oxycodone and the medication was unavailable. There was no documented evidence the emergency supply box of medication was accessed on 6/16/2024 or 6/17/2024 to obtain Oxycodone 5 milligrams for Resident #213. Nursing Note dated 6/18/2024 at 09:32 AM documented the emergency supply box of medication was accessed, and the Resident #213 received Oxycodone that was prescribed for 6 AM. There was no documented evidence Resident #213 received Oxycodone in accordance with Physician's Orders on 6/16, 6/17, and 6/18/2024 to address their pain and provided with alternative pain relief interventions. During an interview on 6/14/2024 at 04:32 PM, Licensed Practical Nurse #13 stated they should have started looking for refills of Resident #213's Oxycodone once there were 8 pills left in the supply. Licensed Practical Nurse #13 stated the incident with Resident #213 was a long time ago and they did not recall what occurred or whether the Nursing Supervisor or Physician were made aware. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 1:47 PM, the Director of Nursing stated nurses should order medication refills from the pharmacy once they have 8 pills left in the supply. The nurse did not reorder Resident #213's Oxycodone until 6/18/2024 and the medication was not reordered when there were 8 pills left in the supply. The Director of Nursing stated doses of Oxycodone were available, but no one accessed the Emergency supply box to retrieve them for Resident #213. The Director of Nursing stated the nurses knew they should never waste or use a pill from another resident's supply of medication. 10 NYCRR 415.12

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 40686 Based on observation, interview, and record review conducted during the recertification survey from 8/6/2024 to 8/13/2024, the facility did not ensure the physician reviewed the resident's total program of care at each visit. This was evident for 1 (Resident #88) of 25 total sampled residents. Specifically, the Physician Assistant did not review a Nursing Pain Evaluation or the Physiatrist's pain management recommendations for Resident #88. The findings are: The facility policy titled Pain Assessment and Management dated 6/2024 documented the physician and staff will establish a treatment regimen based on the resident's medical condition, course of illness, and treatment goals. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and adjust as indicated. On 08/06/2024 at 12:41 PM, Resident #88 was interviewed and stated they recently had a surgical amputation of their left leg above the knee and experienced persistent pain to the surgical site that was not relieved by their current pain medication. Resident #88 reported the pain to the Physician Assistant but there have not been any changes to their treatment plan. The Comprehensive Care Plan related to chronic pain initiated 3/24/2024 and last reviewed 7/30/2024 documented Resident #88 had neuropathy, potential phantom pain, and pain from recent surgery. Interventions included monitoring, recording, and reporting Resident #88's complaints of pain and requests for pain treatment and anticipating Resident #88's need for pain relief timely. A Physiatry Consult dated 7/12/2024 documented Resident #88 was evaluated due to amputation site pain and included a plan to consider increasing Gabapentin to 600 mg three times daily. An ultrasound and/or magnetic resonance imaging of Resident #88's left above the knee amputation stump was recommended to rule out neuroma. A Physician Assistant Note dated 7/24/2024 documented Resident #88 was assessed during a follow-up visit with the Physician Assistant. The note did not document reference to Resident #88's Physiatry Consult dated 7/12/2024. The Nursing Pain Evaluation dated 7/30/2024 documented Resident #88 frequently experienced pain in the past 5 days that interfered with day-to-day activities. On a scale from 1 to 10, Resident #88 reported their pain was a 7. Resident #88 vocally complained of pain daily and did not receive non-medication intervention for their pain. The Physician Assistant Note dated 8/1/2024 documented Resident #88 was visited by the Physician Assistant and received a follow-up assessment. The note did not document an assessment or reference to Resident #88's pain. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders as of 8/13/2024 documented Resident #88 was ordered oxycodone hydrochloride 5 milligrams every 8 hours as needed for a moderate pain level of 6 to 10, Tylenol extra strength 1000 milligrams every 8 hours as needed for a mild to moderate pain level of 1 to 5, Gabapentin 400 milligram 3 times daily for neuropathic pain, and pain level monitoring every shift. There was no documented evidence the Physician Assistant reviewed Resident #88's total program of care, including the Physiatry recommendations from 7/12/2024 and the Nursing Pain Evaluation dated 7/30/2024, at each visit. On 08/14/2024 at 10:05 AM, Licensed Practical Nurse #11 was interviewed and stated Resident #88 expressed a pain severity of 7 out of 10. Resident #88 was referred to the Physiatrist because the oxycodone was not effective. Licensed Practical Nurse #11 stated they did not review the Physiatry Consults and the Physician Assistant was responsible for reviewing and ordering the Physiatrist's recommendations. The Physician Assistant evaluated Resident #88's pain management monthly. On 08/14/2024 at 11:51 AM, the Physician Assistant was interviewed and stated Resident #88 was ordered oxycodone and Tylenol for pain as needed. Resident #88 had a standing order for Gabapentin 400 milligrams 3 times daily for neuropathic pain. The Physician Assistant stated they assessed Resident #88's pain every time they visited the resident. Resident #88 did not report an increase in pain. The Physician Assistant did not assess Resident #88's pain level using a numeric pain scale and stated the resident did not report that their pain was excruciating. The Physician Assistant stated they did not review the pain scale documented by nursing in the resident's medical record unless the resident reported pain at the time of Physician Assistant visit. The Physician Assistant stated they did not review the Nursing Pain Evaluation completed 7/30/2024 for Resident #88. After reviewing medical record with the surveyor, the Physician Assistant stated Resident #88 was evaluated by the Physiatrist on 7/12/2024 and an increase in Gabapentin, ultrasound, and magnetic electronic imaging were recommended. The Physician Assistant was unable to provide documented evidence the Physiatry Consult recommendations were reviewed. On 08/14/2024 at 06:00 PM, the Administrator was interviewed and stated the Physician Assistant or Medical Doctor were responsible for reviewing and determining whether to follow the Physiatrist's recommendations. 10 NYCRR 415.15(b)(2)(iii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, interviews, and record review conducted during the recertification and abbreviated (NY00347185) survey from 8/6/2024 to 8/14/2024, the facility did not ensure sufficient nursing staff to provide nursing and related services to attain or maintain the well-being of each resident in accordance with the facility assessment. This was evident for 2 (2nd and 3rd Floor) of 3 units during staffing review. Specifically, 1) the Facility Assessment did not account for and plan to staff the 2nd and 3rd Floor with their higher resident capacity and census in comparison to the 1st Floor, 2) the projected staffing levels and actual staffing levels were less than the Facility Assessment's projected needs for the resident population of 2.2 Certified Nursing Assistant hours per resident per day, 3) F676 cited for activity of daily living care for Resident #95, and 4) residents reported delays in activities of daily living care related to the facility being short of staff. The findings are: 1) The Facility assessment dated [DATE] documented the facility had 120 beds with 40 subacute care and 80 long term care residents and an average daily census of 114 residents. An average of 71 residents required 1 to 2-person assistance with toileting and 30 residents were totally dependent upon staff for assistance with toileting. The Staffing Pattern documented minimum required Certified Nursing Assistant Hours equivalent to 2.2 hours per resident per day and projected direct care staffing needs as 4 to 5 Certified Nursing Assistants per unit on the 7 AM to 3 PM shift, 3 to 4 Certified Nursing Assistants per unit on the 3 PM to 11 PM shift, and 2 Certified Nursing Assistants per unit on the 11 PM to 7 AM shift. There was no documented evidence the Facility Assessment accounted for differing capacity and acuity on each unit with the 1st floor capacity = 32 residents, 2nd floor capacity = 44 residents, and 3rd floor capacity = 44 residents. 2) On 08/08/2024 at 09:47 AM, the 2nd Floor was observed with a capacity of 44 residents and a census of 42. The 3rd Floor was observed with a capacity of 44 residents and a census of 43. The Projected Staffing planned for 11 Certified Nursing Assistants across 3 shifts for the 2nd and 3rd Floors. Accounting for .5 hours of break for each staff, 11 Certified Nursing Assistants would be able to provide 2.2 hours of resident care for 37.5 residents. There was no documented evidence the facility adequately staffed the 2nd and 3rd Floors for 2.2 hours Certified Nursing Assistant care per resident per day. A sample of Actual Staffing was reviewed: - On 7/22/2024, there were 10 Certified Nursing Assistants across 3 shifts on the 3rd Floor and 9 Certified Nursing Assistants across 3 shifts for the 2nd Floor. - On 7/23/2024, there were 11 Certified Nursing Assistants across 3 shifts for both the 2nd and 3rd Floors. - On 7/24/2024, there were 11 Certified Nursing Assistants across 3 shifts for the 3rd Floor. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 7/26/2024, there were 10 Certified Nursing Assistants across 3 shifts on the 2nd Floor. - On 7/27/2024, there were 10 Certified Nursing Assistants across 3 shifts on the 2nd Floor and 9 Certified Nursing Assistants across 3 shifts on the 3rd Floor. The Actual Staffing from 7/22/2024 to 7/27/2024 documented insufficient staff to provide care for a capacity of 44 residents on the 2nd and 3rd Floors. The Projected Staffing as of 8/9/2024 documented the following numbers of Certified Nursing Assistants were scheduled to work the 2nd and 3rd Floors: - 8/9/2024 = 11 across 3 shifts on the 2nd Floor, 11 across 3 shifts on the 3rd Floor - 8/10/2024 = 11 across 3 shifts for the 2nd Floor, 9 across 3 shifts for the 3rd Floor - 8/11/2024 = 10 across 3 shifts for the 2nd Floor, and 8 across 3 shifts for the 3rd Floor 3) Refer to F676 regarding Activities of Daily Living care for Resident #95. On 8/06/2024 at 10:28 AM, Resident #95's Designated Representative stated the resident waited 12 hours on Sunday (8/4) and 9 hours on Monday (8/5) to have their incontinence brief changed by staff. Actual Staffing for 8/5/2024 on the 3rd Floor documented there were 3 Certified Nursing Assistants on the 7AM to 3PM shift, 3 Certified Nursing Assistants on the 3 PM to 11PM shift, and 2 Certified Nursing Assistants on the 11PM to 7AM shift, indicating, according to the Facility Assessment, the floor was short of staff. 4) On 8/06/2024 at 12:14 PM, Resident #7 was observed in their room in bed with a strong odor of urine. At 12:21 PM, lunch arrived on the unit and staff began serving residents their meal trays. At 12:55 PM, Resident #7 was served their lunch tray and began setting up their meal to eat. A strong odor of urine was still present as Resident #7 began eating their lunch. On 8/7/2024 at 11:11 AM, Resident Council Meeting was held and Resident #96 and #76 reported they had concerns regarding the facility being short of staff. Resident #96 stated there were times they looked for staff on the 11 PM to 7 AM shift and were unable to locate anyone on the unit to assist them. Resident #76 stated a few nights ago, they were not placed back into bed until 10:30 PM because the unit was short of staff. Resident #96 reported their concerns to the Administrator and was told the facility is not short of staff. On 08/09/2024 at 06:18 AM, Licensed Practical Nurse #21 was interviewed and stated the 3rd Floor census was 43 residents. There were 2 Certified Nursing Assistants assigned that were responsible for assisting 5 residents with morning care and getting them up and out of bed. The Certified Nursing Assistants were responsible for checking every resident for toileting and incontinence care every 2 hours and with providing monitoring every 30 minutes to a few new residents that were at risk for falls. There were Certified Nursing Assistants that called out on an average of 3 out of every 10 days Licensed Practical Nurse #21 worked. The Nursing Supervisors attempt to get coverage and use a staffing application called Clipboard to post that the shift needed to be filled. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/09/2024 at 06:35 AM, Certified Nursing Assistant #23 was interviewed and stated they have worked on the 2nd and 3rd Floors and always work the 11PM to 7AM shift. There are times that the unit runs short of staff due to call outs. The Nursing Supervisor tried to adjust the assignments and send someone from another unit to cover if the floor was running short of Certified Nursing Assistants. Certified Nursing Assistant #23 stated they were asked to work a double shift to cover other shifts that were short of staff approximately 2 times monthly. On 08/09/2024 at 06:43 AM, Certified Nursing Assistant #22 was interviewed and stated they were a per diem staff and have worked all shift and on all units previously. All residents on the 2nd Floor were checked every 2 hours to see if they needed toileting assistance. There were a few residents that got up overnight to use the bathroom, but they did not require total assistance with their activities of daily living. Certified Nursing Assistant #22 stated they were assigned 22 residents and approximately 11 of them required assistance when being toileted. On 08/09/2024 at 05:12 PM, Licensed Practical Nurse #10 was interviewed and stated they were per diem, worked for the facility for 2 months, and had been assigned to the 3PM to 11 PM shift on all units. The census on the 3rd Floor was currently 42 residents and there were 4 Certified Nursing Assistants assigned for the shift. The 3rd Floor was usually assigned between 3 and 4 Certified Nursing Assistants and the staff were not able to handle their assignments There were times that aides were assigned up to 15 residents and the Licensed Practical Nurse #10 had to pitch in to help them. Licensed Practical Nurse #10 stated they help when they can and approximately 15 of the residents on the unit required 2-person assistance with activities of daily living. On 08/14/2024 at 11:30 AM, Certified Nursing Assistant #8 was interviewed and stated Resident #10 required 2-person assistance with activities of daily living. Certified Nursing Assistant #8 stated they have not gone to Resident #10 to provide them with hygiene or incontinence care yet and had only gone in to serve Resident #10 their breakfast earlier. Resident #8 was also under their care, also required 2-person assistance with activities of daily living, and Certified Nursing Assistant #8 stated they also have not been able to attend to Resident #8 yet this morning. Resident #8 was still in bed and had not received incontinence care yet. Certified Nursing Assistant #8 had 11 residents on their assignment this morning, there were 4 Certified Nursing Assistants assigned to the unit with a census of 44 residents, and 3 of the residents on their assignment required 2-person assistance. Certified Nursing Assistant #8 was per diem and had mostly been assigned to the 1st floor where they have 8 residents on their assignment. The 1st floor residents require less assistance. Certified Nursing Assistant #8 stated they noticed the residents on the 2nd floor required more assistance with more residents requiring 2-person assistance with activities of daily living. On 08/14/2024 at 03:10 PM, the Staffing Coordinator was interviewed and stated the nursing staffing, including the Certified Nursing Assistants, was changed by the Nursing Administration. The Staffing Coordinators was unable to provide an explanation for unfilled slots for Certified Nursing Assistants on the projected staffing sheets for 8/9/2024 through 8/11/2024. On 08/14/2024 at 03:25 PM, the Assistant Director of Nursing was interviewed and stated they verified whether staff showed up and filled in the staffing to be posted every evening shift. The Nursing Supervisor was responsible for confirming the staffing on each unit and checking off attendance. The Assistant Director of Nursing was unable to provide an explanation for 8/6/2024 staffing not being confirmed and documented on the staffing sheet. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/14/2024 at 05:57 PM, the Director of Nursing was interviewed and stated they tried to adapt and address residents' needs. All nursing staff was responsible for assisting residents with their activities of daily living as needed. The facility had incentives like gift cards and [NAME] tickets for concert tickets in place for staff that assisted with finding new Certified Nursing Assistants to hire. The Administrator was responsible for setting the par ratio levels for nursing staff. On 08/14/2024 at 06:13 PM, the Administrator was interviewed and stated there were complaints from residents about staffing when they first started working for the facility, but nursing staffing has significantly improved. The par levels for Certified Nursing Assistants were based off the acuity and census of the units. The 1st Floor capacity was 32 residents, and the 2nd Floor and 3rd Floor capacities were 44 residents. The Facility Assessment provided a range of 4 to 5 Certified Nursing Assistants for the 7AM to 3PM shifts for all [NAME] because the 1st Floor was scheduled to have 4 aides while the other floors were scheduled to have 5 aides for that shift. The facility attempts to schedule according to their Facility Assessment. If the Projected Staffing was less than the Facility Assessment par levels, it was because the Staffing Coordinator was working to fill the empty slots and find coverage for those shifts. The facility tried their best to have sufficient staff including weekly orientation of new staff, stipends, and no-callout bonuses. The retention rate of staff has increased and there was more staffing stability. The Administrator stated there were no quality-of-care issues related to staffing that they were aware of. 10 NYCRR 415.13(a)(1)(i-iii)

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Sans Souci Rehabilitation and Nursing Center	115 Park Avenue Yonkers, NY 10703

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00338972) survey from 8/6/2024 to 8/14/2024, the facility did not ensure each resident received behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This was evident for 1 (Resident #10) of 25 total sampled residents. Specifically, Resident #10's behavioral health plan of care was not individualized, reviewed, and revised to address symptomology related to their mental illness diagnoses. The findings are: Resident #10 had diagnoses of schizoaffective disorder, bipolar disorder, catatonia, and major depressive disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #10 was moderately cognitively impaired, did not display mood symptoms, and was physically aggressive towards others. The Minimum Data Set 3.0 assessments, dated 4/10/2024 and 5/13/2024, documented Resident #10 was severely cognitively impaired and did not display any behavioral symptoms. The assessments documented Resident #10 did display mood symptoms including little interest or pleasure in doing things, feeling down, trouble sleeping, feeling tired, poor appetite, and trouble concentrating. The Preadmission Screening and Resident Review Form dated 3/17/2023 documented Resident #10 was diagnosed with a serious mental illness and did not require a Level II Referral for specialized services because they were being admitted to the facility for a very brief and finite stay. The Level II Outcome Form dated 9/14/2023 documented Resident #10 was readmitted to the facility from the hospital, required nursing facility care, and was approved for admission to the facility. Resident #10's necessary services and supports included a person-centered psychiatric care plan, ongoing psychiatric consultation, recovery-oriented clinical counseling focused on goal achievement, and therapeutic group interventions, continued symptom monitoring, recreational groups and activities, and a written safety plan to address a history of suicidal ideation. The Comprehensive Care Plan related to preadmission mental illness screening dated 2/6/2024 documented Resident #10 would be assisted in identifying their support systems and symptoms of mental health behavior and would be encouraged to verbalize feelings and emotions. There was no documented evidence the care plan was reviewed or revised since 2/6/2024. The Comprehensive Care Plan related to mood symptoms initiated 2/6/2024 documented Resident #10 was provided with emotional support and psychiatric intervention. Interventions included allowing Resident #10 to participate in religious activities and to process their feelings. There was no documented evidence the care plan was reviewed or revised since 2/6/2024. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to behavior initiated 2/6/2024 documented Resident #10 was uncooperative, noncompliant, threw themselves on the floor, and crawled around their room. Interventions included assisting Resident #10 back to their room, offering position change, offering toileting, providing an activity of choice, redirection, and removing the Resident #10 from the environment. The care plan was reviewed on 4/19/2024 and no new interventions were documented. The Comprehensive Care Plan related to activities created on 2/12/2024 and initiated on 8/13/2024 documented Resident #10 had limited participation in recreation programs due to not being able to be taken out of bed. Resident #10 received 1-to-1 visits in their room. Nursing Behavior Note dated 2/26/2024 documented Resident #10 climbed out of bed and placed themselves on the floor and was combative. The section for Behavioral Triggers, Interventions, and Resident Response were blank with no documentation present. Physician Assistant Note dated 2/29/2024 documented Resident #10 was evaluated for placing themselves on the floor, wheeling themselves everywhere, and attempting to get up from a sitting position. Resident #10 was unable to be redirected. Intramuscular Haldol 4 milligrams was administered to Resident #10 due to their risk for falls. Nursing Behavior Notes dated 3/3/2024 at 11:33 AM and 2:28 PM documented Resident #10 made inappropriate comments and gestures to staff, threw themselves on the floor, and attempted to go to the elevator. Redirection had little effect. Psychiatry Consult dated 3/4/2024 documented Resident #10 was calm during assessment and appeared catatonic. Lorazepam .5 milligrams daily for 7 days was ordered and non-pharmacological techniques to enhance Resident #10's mood was recommended. Physician Assistant Note dated 3/8/2024 documented the nurse requested Resident #10 be evaluated for agitation and aggressive behavior that was hard to redirect. Resident #10 reported they bit a staff member because the staff member did not listen to them. Resident #10 was transferred to the hospital for psychiatric evaluation. The Nursing Admission Evaluation dated 4/3/2024 documented Resident #10 did not display delusions, hallucinations, or behaviors. The Physician Admission History and Physical dated 4/4/2024 documented Resident #10 was readmitted after being psychiatrically hospitalized , had occasional blank stares with short responses, and would follow-up with the facility Psychiatrist. Resident #10's psychiatric symptoms and psychotropic drug use were not documented. A Social Work Note dated 4/4/2024 documented Resident #10 was readmitted to the facility with mood symptoms present and cognitive impairments. Psychology and Psychiatry interventions were ongoing. There was no documented evidence Resident #10 was referred for Psychology evaluation or intervention following psychiatric inpatient hospitalization from [DATE] to 4/3/2024. The Social Service Evaluation dated 5/13/2024 documented Resident #10 did not display any behavior symptoms, a care plan was not initiated, and behavior tracking was not initiated. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nursing Assistant Documentation Report from 6/1/2024 through 8/8/2024 documented Resident #10 did not engage in any 1-to-1 activities, group activities, independent activities, or integrative therapy including non-pharmacological modalities. Physician Orders as of 8/13/2024 documented Resident #10 received psychiatry consults as needed, Buspirone 5 milligrams 3 times daily for anxiety, Lorazepam .5 milligrams once daily for anxiety, and Olanzapine 20 milligrams once daily for schizophrenia. There was no documented evidence individualized non-pharmacological interventions were developed and implemented to address Resident #10's behavior symptoms related to diagnosis of schizoaffective disorder, bipolar disorder, and catatonia. There was no documented evidence the Level II Preadmission Screening recommendations and interventions were incorporated in Resident #10's plan of care or that the resident's plan of care was reviewed and revised if ineffective. On 08/14/2024 at 11:30 AM, Certified Nursing Assistant #8 was interviewed and stated they have cared for Resident #10 previously. The Certified Nursing Assistant tasks listed in the computer provided an alert and instructions on how to address a resident's behaviors. There were no behavior alerts for Resident #10. Certified Nursing Assistant #8 stated they were not aware of Resident #10 having any behaviors and the charge nurse did not discuss Resident #10 when they gave report to the staff at the beginning of the shift. Certified Nursing Assistant #8 had no issues when interacting with Resident #10 during breakfast service. Resident #10 was verbal, interactive, and knew how to use the call bell appropriately. On 08/14/2024 at 12:03 PM, the Physician Assistant was interviewed and stated Resident #10 had psychiatric disorders and was evaluated by the Psychiatrist on 6/10/2024 and 8/5/2024. Resident #10 had episodes of being irritable and combative during care. Prior to inpatient psychiatric hospitalization in 3/2024, Resident #10 was confused, and staff had to physically assist the resident back to their wheelchair because the resident attempted to get up without assistance and was a fall risk. Resident #10 became combative when staff attempted to put them back in their wheelchair, was noncompliant with care, threw themselves on the floor, would not let staff put them back to bed, and bit a staff member. Labs were done 3/1/2024 to rule out a medical cause for the behavior. Resident #10 was evaluated by the Psychiatrist on 3/4/2024 and the Physician Assistant stated they tried to address the resident's behavior by talking with the resident and ordering Ativan. The Physician Assistant did not know of any non-pharmacological interventions used by facility staff to address Resident #10's behaviors and stated they call the Medical Doctor and the Psychiatrist when Resident #10 displayed behaviors. The Physician Assistant did not know Resident #10 was referred for a Level II Preadmission Screening evaluation, did not know there were Level II recommendations were for Resident #10, and did not know where to find Level II evaluation information in the electronic medical record. The Physician Assistant stated Level II Preadmission Screening information was not communicated to them by facility staff. Resident #10 was not aggressive towards or a danger to other residents. Residents with unmanageable behaviors were sent to the hospital for evaluation. Resident #10 was hospitalized due to their noncompliance. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/2024 at 02:32 PM and 03:28 PM, the Director of Social Work was interviewed and stated the facility staff were aware of Resident #10's psychiatric diagnoses prior to admission and accepted the resident into the facility. Resident #10 did not exhibit behaviors and was referred for a Level II Preadmission Screening evaluation because of their serious mental illness diagnoses - schizoaffective disorder, bipolar disorder, and catatonic disorder. The Director of Social Work stated they were unfamiliar with the diagnosis catatonic disorder but thought it was in relation to a display of manic symptoms. Resident #10 began displaying behaviors a few months after admission to the facility. The Level II recommendations included Psychiatric services, medication management, and group activities. The Director of Social Work stated they communicated Level II evaluations and recommendations to the nurse manager, Director of Nursing, Psychiatrist, and Psychologist. The Recreation Department conducted group activities and attempted to include Resident #10. On 8/21/2023, Resident was referred for a psychology consult but did not receive ongoing services by a psychologist. Resident #10 has not been referred to psychology since then. Resident #10 was psychiatrically hospitalized after they bit providing them care and crawled on the floor. The Director of Social Work stated they did not refer Resident #10 for another Level II evaluation following this change in behavior and subsequent psychiatric hospitalization . No new interventions were developed or implemented upon Resident #10's readmission to the facility and their behavior care plan was not revised. The Administrator issued a facility-initiated discharge notice to Resident #10 because the facility could not manage the resident's behavioral health needs. A care plan meeting was held with the Administrator, Director of Social Work, Ombudsman, Designated Representative, and Director of Nursing to discuss appropriate transferring Resident #10 to a more appropriate facility that can manage the resident's behaviors. On 08/14/2024 at 06:13 PM, the Administrator was interviewed and stated the facility initiated discharge and issued discharge notices when residents were a danger to themselves or others. Resident #10 had unmanageable behaviors and multiple psychiatric hospitalization s since being admitted to the facility. Administration attempted to find a nursing facility with psychiatric care more appropriate for Resident #10. After Resident #10's readmission to the facility, a care plan meeting was held, and the Designated Representative was informed the facility could not adequately accommodate Resident #10's behaviors. The Administrator stated they have not received the same complaints regarding Resident #10's behavior as they did prior to the resident's hospitalization . The Administrator stated they were aware of Resident #10's Level II evaluation related to mental illness and staff used non-pharmacological interventions such as assigning 2 staff to care for behavioral residents, leaving the resident alone to calm down, and redirection. The Social Work Department was responsible for coordinating the Level II referral process. 10 NYCRR 415.12(f)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41666 Based on observations, record review, and interviews conducted during the recertification survey from 08/6/24 to 08/14/24, the facility did not ensure a medication error rate of no more than 5%, during a medication administration observation, when 2 of 25 opportunities (8%) resulted in error for 1 of 4 residents (Resident #5). Specifically, 1) Resident # 5 was administered a crushed form of Enteric coated aspirin instead of chewable and a crushed form of Depakote delayed release tablet. The findings are: The facility's policy titled Administering Medications dated 06/07/24 documented medications are administered in a safe and timely manner and are administered in accordance with prescriber's orders. Resident #5 was admitted to the facility with diagnoses including but not limited to seizures, schizophrenia, hypertension. The current physician orders as of 8/9/24 documented Aspirin oral tablet chewable 81 mg, give one tablet by mouth one time a day for prophylaxis and Depakote tablet delayed release 500 mg, give one tablet by mouth two times a day for mood disorder. In addition, the current physician orders as of 8/9/24 documented may crush meds or open capsules and administer in applesauce as needed unless contraindicated. Manufacture's instructions for Enteric-Coated Aspirin include do not crush or chew enteric-coated tablets. Doing so can increase stomach upset. Do not crush or chew extended-release tablets or capsules. Doing so can release all of the drug at once, increasing the risk of side effects (https://my.clevelandclinic.org). The current physician order as of 08/09/24 documented Resident #5 received a regular diet, regular texture, thin liquids. During a medication administration observation on 08/09/24 at 9:09 AM, Licensed Practical Nurse #14 was observed crushing Resident #5 Depakote Delayed Release 500 mg tablet and Ecotrin enteric coated aspirin 81 mg prior to mixing the medication with applesauce and administering to Resident #5. The medications were reconciled and were reviewed against the active physician orders as of 08/09/24. The medications included Depakote tablet delayed release 500 mg one tablet by mouth two times a day and Aspirin oral tablet chewable 81 mg, give one tablet by mouth one time a day. During an interview with Licensed Practical Nurse #14 on 08/09/24 at 11:59 AM they stated they should not have given the Ecotrin enteric coated aspirin because chewable was ordered and a supply of chewable was available. The Licensed Practical Nurse #14 stated they were aware the Depakote could not be crushed and did not notice the blister pack had a sticker which says do not crush but they knew the resident would not swallow the pills. They did not inquire if another form was available. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing on 08/14/24 at 11:46 AM they stated all nurses have to give out medications correctly by following medication instructions. It was okay to honor resident preferences, but it needed to be compliant. If a medication was not crushable nurses needed to let the physician know so a suspension or crushable form could be ordered. 10NYCRR 415.12(m)(1)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50816 Based on observation, interview, and record review conducted during the Recertification and Abbreviated surveys (NY00341698) on 8/6/2024 to 8/14/2024, the facility did not ensure that rehabilitative services were provided for 1 of 2 residents (#81) reviewed for weight loss. Specifically, Resident #81 the physician's order for a Speech Therapy evaluation for slow eating and chewing, was not completed. Findings include: The facility policy titled Rehabilitation Services created on 5/2022 documented Physical Therapy, Occupational Therapy and Speech Therapy are provided in this facility for patients who present with mobility impairments, functional impairments, speech/language deficits, and swallowing deficits that require skilled intervention to either improve function or reduce caregiver burden. Upon admission to this facility, at any time a significant change of condition occurs and periodically throughout a resident's stay, the physician and staff will assess the resident's physical condition and functional status. A physician order for an evaluation by a qualifying therapist is required to initiate rehabilitation services. Once the physician order has been placed, the respective discipline will have an evaluating clinician perform an evaluation. Resident # 81 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, major depressive disorder, mood disorder and anxiety. The Significant Change Minimum Data Set Assessment (an assessment tool) dated 7/26/2024 documented Resident #81 had severe cognitive impairment and required partial/moderate assistance with eating, weight loss of 5% or more in the last month or 10% or more in last 6 months. The Care Plan created on 2/27/2023 and updated 7/28/2024 documented the resident had a nutritional problem or potential for a nutritional problem related to dementia, depression, hypertension. Interventions included to provide diet as ordered, provide supplements, allow time for completion of meals, monitor weights, administer medications. The 7/17/2024 dietary note documented significant/undesirable weight loss noted in 3 and 6 months. Weight loss is 7.5 % in 3 months and 10.5 % in 6 months. Resident#81 takes more time with meals, can be challenging to encourage at mealtime and may refuse assistance as experienced. Acknowledge dementia diagnosis which contributes status. The Physician order dated 7/17/24 documented for Speech Therapy to evaluate due to slow eating and chewing. Further review of the resident's medical record revealed no documented evidence the speech therapy evaluation was completed for resident #81. During mealtime observations on 8/9/24 at 12:06 PM and 6:45 PM, on 8/12/24 at 8:45 AM and 12:33 PM, on 8/13/24 at 12:48 PM and on 8/14/24 at 9:20 AM, Resident #81's meals were served in soup bowls. Resident #81 held the bowl of food and staff was observed feeding the resident. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 8/9/24 at 10:49 AM, the Clinical Nutrition Manager stated the resident had a 7. 5 % weight loss in 3 months from April to July. The Clinical Nutrition Manager stated Resident #81 was at risk for weight loss as she ate very slowly. When interviewed on 8/12/24 at 11:06 AM, the Occupational Therapist who was covering for Director of Rehabilitation Department, stated that when there was an order for a speech therapy evaluation, the speech therapist would observe the resident at mealtime and document the evaluation. Occupational Therapist stated, while checking Resident # 81 medical record, that there was no documentation the speech evaluation was conducted for Resident #81. When interviewed on 8/12/24 12:41 PM. the Speech Therapist #17 stated that on 8/2/24 they were informed by Rehabilitation director that there was an evaluation and treatment order from 7/17/24 for Resident # 81. The Speech Therapist stated they screened the resident on 8/2/24 but did not document the screen. The Speech Therapist stated they should have documented the screen. When interviewed on 8/13/24 at 11:46 AM, the Director of Rehabilitation Department stated that when an order was put in for evaluation, the resident should be seen within 72 hours. Resident #81 should have been screened and evaluated as per physician's order within the 72 hours. 10 NYCRR 415.16(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on observation, record review and interviews conducted during a recertification survey (08/06/24 to 08/14/24), the facility did not ensure infection control prevention practices including hand hygiene were maintained to help prevent the development and transmission of communicable diseases and infections for 2 (#15 and #4) of 32 sampled residents. Specifically, 1) Certified Nurse Aide #1's hand came in contact with Resident #15 food a during lunch meal observation and Licensed Practical Nurse #11 did not follow proper hand hygiene during a wound care treatment for Resident #4. 1) Resident #15 was admitted with diagnoses which included Hypertension, Diabetes Mellitus, Coronary Artery Disease. The Minimum Data Set, an assessment tool dated 6/30/24 documented the resident had mild cognitive impairment and required tray set up for eating. During an observation on 08/06/24 at 12:14 PM Certified Nurse Aide #1 delivered the lunch tray to Resident #15, opened the tray, and began to open up utensils and beverage containers. The Certified Nurse Aide was observed with their uncovered palm of the hand down on the resident's hamburger bun and cut the hamburger in half. During an interview with Certified Nurse Aide #1 on 08/06/24 at 12:43 PM they stated they heard about not touching the food on residents' tray but did not think about it when they were cutting the burger. They further stated they probably should have used a fork and knife to cut the burger. 2) Resident #4 has diagnosis of multiple sclerosis, hemiplegia and dementia. The Minimum Data Set, an assessment tool dated 6/23/24 documented the resident had severe cognitive impairment and was dependent on staff for all activities of daily living and had a Stage 3 and Stage 4 pressure ulcer. The current physician's orders as of 08/12/24 documented Silvadene cream to right hip, cover with dry protective dressing daily. During a wound treatment observation on 8/12/24 at 11:57 AM with Licensed Practical Nurse #11 the resident was positioned for comfort. The Licensed Practical Nurse gathered supplies, washed hands at the sink and prepared field with clean supplies. The nurse removed the old dressing, washed hands and cleaned wound. A moderate amount of drainage was observed as the wound was cleaned and dried. Gloves were doffed and a new pair was donned without performing hand hygiene. The Licensed Practical Nurse applied the Silvadene cream as prescribed with a tongue depressor and applied a dry protective dressing. During an interview on 08/12/24 at 12:15 PM with Licensed Practical Nurse #11, they stated they had a lot on their mind and was thrown off because they had been doing dressings on another floor. They stated was not thinking and just kept going. Knew they should have washed hands in between but did not do it this time. During an interview with the Director of Nursing on 08/14/24 at 11:02 AM they stated there have been in services on hand hygiene and did rounds but more education was needed. 10 NYCRR 415.19 (b) (4)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41666 Based on record review and interview during the recertification survey conducted 08/06/24 to 08/14/24, the facility did not ensure each resident was offered pneumococcal immunizations and received education regarding the benefits and potential side effects of the immunizations for 1 of 5 residents (Residents #51) reviewed. Specifically, there was no documented evidence Resident #51 was offered, declined, or educated on the pneumococcal immunization. Findings include: The facility policy titled Pneumococcal Vaccine last revised October 5, 2017, documented the facility will ask residents on admission if they have received the pneumococcal vaccine and the medical record will be reviewed to confirm this information. If the resident has not received the pneumococcal vaccine, information will be given to the resident/resident representative concerning pneumococcal vaccine and the Vaccine Information Sheet will be reviewed. The resident will be given the opportunity to ask questions concerning risks and benefits. If the resident wishes to receive the vaccine the resident/resident representative will be asked to sign the consent/declination form. Resident #51 had a diagnoses history of Type II Diabetes Mellitus, Acquired Absence of left leg below knee, acquired absence of right leg below knee, end stage renal failure requiring dialysis. The Minimum Data Set, an assessment tool dated 6/27/24 documented the resident had mild cognitive impairment and was independent for self-care care. The pneumococcal vaccine was not up to date and not offered by the facility. There was no documented evidence that the resident/resident representative received education, was offered the vaccination, or declined the pneumococcal vaccine. During an interview on 08/09/24 at 04:15 PM, with the Infection Preventionist they stated that upon admission residents were asked if they are up to date with their vaccines and if not, the facility would look in the New York State data base and admission documents for pneumococcal vaccines. The Infection Preventionist stated resident records were not complete and did not know why but the resident had been at the facility since April and their pneumococcal vaccine status should have been obtained by now. 10NYCRR 415.19 (a) (1-3)