STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335440	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Poughkeepsie Ctr for Nursing & Rehab	100 Franklin Street Poughkeepsie, NY 12601

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification and Abbreviated Surveys (NY 00335861) from 8/13/24-8/20/24, the facility did not ensure that they developed and implemented a baseline care plan within 48 hours of the resident's admission, that included the minimum healthcare information necessary to properly care for a resident including, but not limited to initial goals, a list of current medications, dietary instructions, and services/ treatments to be administered by the facility and personnel acting on behalf of the facility for 2 of 2 residents (Resident #241 and #392) reviewed for admission. Specifically, 1) Resident #241 was admitted on [DATE] and their Baseline Care Plan was not developed or implemented until 3/11/24; 2) Resident #392 was admitted on [DATE] and their Baseline Care Plan was not developed or implemented until 8/16/24, which was not within 48 hours of admission. Findings include: The 10/17/23 facility policy titled Baseline/Comprehensive Person Centered Care Plan documented that a baseline care plan must be developed within 48 hours of admission. The baseline care plan includes at least a minimum of healthcare information necessary to provide the proper care for the resident, establish initial goals (include the resident's goals & preferences), and orders from the healthcare provider, dietary, therapy, social services and, Preadmission Screening and Resident Review(if applicable). 1) Resident #241 was admitted to the facility on [DATE] with diagnoses including cardiomyopathy, complex regional pain syndrome, and fracture of the left tibia (lower leg bone). The 3/11/24 5-day Minimum Data Set documented that Resident #241 was not assessed for cognition status. Required setup with eating, was maximal assistance with toileting, and required moderate assistance with bed mobility and transfers. Upon review of Resident #241's care plans, there was no documented evidence that the base line care plan was developed or implemented within 48 hours of Resident #241's admission on 3/8/24. The baseline care plan was not initiated until 3/11/24. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission summary nursing progress note dated 3/8/24 at 8:31 PM by Licensed Practical Nurse #24 documented that Resident #241 was admitted to the unit from the hospital via wheelchair with a discharge diagnosis of a left tibial fracture. Resident #241 had a past medical history of breast cancer, osteoporosis, non-ischemic cardiomyopathy, chronic musculoskeletal pain, complex regional pain syndrome, and pulmonary embolism(on Eliquis). Resident #241 was alert and oriented times 4, had no cough, no wheezing, and shortness of breath. Resident #241 had reported pain in left leg(9/10) with movement. Resident #241's skin was intact, abdomen was non tender on palpation. Resident #241 reported that they were continent of bowel and bladder and that their last bowel movement was on 3/7/24. Resident #241 was observed with a left knee immobilizer in place and was non weight bearing to the left extremity. Resident #241 was a high fall risk and had a good appetite. During an interview on at 08/16/24 02:21 PM, Licensed Practical Nurse #24 stated that Resident #241 was admitted on [DATE], and that they did the nursing admission evaluation, and that a registered nurse did not assist them with evaluating Resident #241. Licensed Practical Nurse #24 stated that when a registered nurse is in the facility, they are supposed to do a final review of the licensed practical nurses' evaluation and initiate the care plans. During an interview on 08/20/24 at 09:39 AM, the Director of Nursing stated that a base line care plan must be initiated within 48 hours of a resident's admission, because it provides instructions for the staff to follow that is needed to provide care to the resident. The Director of Nursing stated that if a licensed practical nurse does a nursing admission or readmission evaluation, they expect a registered nurse to sign off on the licensed practical nurse's evaluation within 24 hours. The Director of Nursing stated that there was a registered nurse in the facility on 3/8/24, 3/9/24, and 3/10/24 for all 3 shifts, therefore a base line care plan should have been initiated within 48 hours of Resident #241's admission to the facility and the registered nurse assessment for Resident #241 should have been done as well. During an interview on 08/20/24 at 09:51 AM, the Director of Clinical Operations stated that Resident #241's base line care plan was initiated on 3/11/24 and was unable to give an explanation as to why it was not developed or implemented within 48 hours of Resident #241's admission on 3/8/24. The Director of Clinical Operations stated that if a licensed practical nurse does a nursing admission or readmission evaluation, an alert pops up in point click care for a registered nurse to initiate a base line care plan, and that the registered nurse will have to go in and do their portion of the admissions evaluation so that care plans will generate. The Director of Clinical Operations stated that if a licensed practical nurse is documenting on the Nursing Admission or Readmission Evaluation form, none of the care plans will open because a licensed practical nurse cannot initiate care plans. Furthermore, the Director of Clinical Operations stated that Resident #241 was not assessed by a registered nurse prior to 3/11/24 and was unable to provide documented evidence of a registered nurse assessment and would follow up with the Nurse Practitioner to see if they evaluated Resident #241 during their admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 10:30 AM, Registered Nurse Manager #25 stated that they initiated Resident #241's baseline care plan on 3/11/24, which was not within 48 hours of Resident #241's admission, and that baseline care plans must be initiated within 48 hours of admissions. Registered Nurse Manager #25 stated they were not working when Resident #241 was admitted on [DATE] and that when they reported to work on 3/11/24, they reviewed all admissions on the unit and noticed that Resident #241 did not have any care plans in place and initiated the base line care plan. Registered Nurse Manager #25 stated that there were registered nurses in the building for the whole weekend after Resident #241's admission, and that anyone of the registered nurses could have initiated the baseline care plan. During an interview on 08/20/24 at 10:56 AM, the Nurse Practitioner stated that they are in the facility Monday- Friday and normally try to see residents on the first day of admission or within 24 hours of admission. The Nurse Practitioner stated that they never evaluated Resident #241 during their stay at the facility, because Resident #241 came in on 3/8/24 during evening shift and was discharged on [DATE]. 49255 2) Resident #392 was admitted on [DATE] with diagnoses of dependence on supplemental oxygen, heart failure, and muscle weakness. The Admission Minimum Data Set assessment tool dated 8/16/24 documented the resident was cognitively intact, required supervision or set up for activities of daily living and used continuous oxygen therapy on admission. The record review showed the baseline care plan documented with completion date on 8/16/24. When interviewed on 08/20/24 at 09:02 AM the Director of Clinical Operation stated that a baseline care plan was built on a nursing assessment. They stated a baseline care plan must be initiated within 48 hours. 10 NYCRR 415.11 (c)(1)

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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. 44673 Based on observation, record review and interview during the recertification survey from 8/13/24-8/20/24, the facility did not ensure 1 of 4 residents (Resident #123) reviewed for pressure ulcers, received care and services to prevent new pressure ulcers from developing. Specifically, Resident #123's heels were not off-loaded according to the physicians' orders. The findings are: Resident #123 had diagnoses of chronic obstructive pulmonary disease, fracture of neck of right femur, and muscle weakness. The 5/31/24 Quarterly Minimum Data Set (resident assessment tool) documented Resident #123 had severely impaired cognition and was at risk for pressure ulcers. The 3/23 Policy and Procedure titled Wound Prevention Program documented the facility will identify potential risk factors and implement preventive measures to prevent skin breakdown. The 3/17/23 Physician's Order documented to offload heels when in bed. The 2/8/24 Pressure Ulcer Care Plan documented to off load heels. The 4/11/24 Certified Nurse Aide Care Kardex documented to off load heels at all times. During an observation on 8/13/24 at 11:52 PM, Resident #123 was lying in bed, heels were not off loaded. During an observation on 8/19/24 at 1:00 PM, Resident #123 was lying in bed on their back and heels were not offloaded. During an interview on 8/19/24 at 12:00 PM, Certified Nurse Aide #3 stated they usually did not have Resident #123 on their assignment and did not know if the resident's heels were supposed to be off loaded. During an interview on 8/19/24 at 12:30 PM, Licensed Practical Nurse #4 stated they were responsible for the pressure reducing devices and ensuring Resident #123's heels were off loaded. They stated if Resident #123's heels were not off-loaded, their skin could break down. During an interview on 8/19/24 at 12:35 PM, Licensed Practical Nurse Unit Manager #5 stated the nursing staff were responsible for off-loading her heels. They stated that if Resident#123 heels were not off loaded, they were at risk for skin breakdown. 415.12 (c) (1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 8/13/24-8/20/24, the facility did not ensure adequate supervision was provided and that the residents environment remained as free of accidents hazards as possible for 1 of 2 residents (Residents #170) reviewed for accidents. Specifically, for Resident #170 had a history of falls and was observed in their room alone in their room in their wheelchair, rolling wobbly over a floor mat that was beside their bed. The findings are: The facility policy titled Fall Prevention Program dated 3/2002 and revised on 03/2023 documented that that the purpose of this program is to reduce the incidents of falls in residents identified at high risk, developing interventions, and incorporating them into the Resident Care Plan. Resident #170 was admitted on [DATE] with diagnoses including dementia, falls, and thoracic (T9) vertebral (spine) fracture. The 5/16/24 5-day Minimum Data Set documented that Resident #170 had severely impaired cognition, required set up with eating, required extensive assistance with toileting and transfers, and required supervision with bed mobility. Resident #170 had an unspecified fracture of the T9-T10 Vertebra from an unspecified fall. The Fall Care plan dated 5/17/24 documented that Resident #170 had potential for falls with or without injury due to falls with no injury on 5/16/24, 5/22/24, 7/2/24, and 7/23/24. Interventions included to have a physical and occupational therapy evaluation done(updated on 5/10/24), educating the resident to always lock the chair before sitting(updated on 5/22/24), putting Resident #170 back to bed in the night when it is too late for a restful night and not sitting at the nurses' station(updated on 5/17/24), and applying a Dycem cushion to the wheelchair (5/17/24). Upon review of Resident #170's Care Plans, Resident Care Profile, and Kardex, there was no documented evidence regarding interventions or instructions to place floor mats on any side of Resident #170's bed. The 5/23/24 Physicians orders documented that Resident #170 was on fall precautions. The 5/22/24 Accident and Incident report and nursing progress note dated 5/22/24 at 9:56 PM documented that an unwitnessed fall occurred, and Resident #170 was found sitting on floor at the nurse's station close to the resident's chairs leaning on a chair with their legs out and they arms by their side. No injuries noted, the resident was assessed and assisted by 2 staff off the floor and taken to the bathroom and put in bed. The 7/2/24 Accident and Incident Report and nursing progress note dated 7/2/24 at 9:35 PM documented Resident #170 had an unwitnessed fall and was found lying on a floor mat, in another resident's room around 8:30 PM. The resident was seated at the nurses' station for safety monitoring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/23/24 Accident and Incident Report documented that at 09:30 PM, Resident #170 had an unwitnessed fall in the dining room and sustained a skin tear to the right arm. When observed on 08/13/24 at 11:45 AM, Resident #170 was in their room alone slouched down in their wheelchair, moving back in forth rolling over the floor mat and wobbling. The floor mat was in place on the right side of their bed and a rolling walker was directly behind their wheelchair. Resident #170 was observed crying and talking to themselves. On 08/13/24 at 12:10 PM, Resident #170 was observed in their room alone, asleep, and slouched down in their wheelchair. During an interview on 08/19/24 at 02:10 PM, Certified Nurse Aide #23 stated that Resident #170 should be in a supervised area but will leave the supervised areas and go to their room by themselves, and when staff tries to redirect them, they get verbally and physically aggressive. Certified Nurse Aide #23 stated that they were unaware the resident had floor mats and the floor mats were not on the Kardex (resident care instructions). During an interview on 08/19/24 at 02:11 PM, Licensed Practical Nurse Unit Manager #5 stated Resident #170 had attention seeking behaviors, was very controlling and verbally abusive, and that the medical providers had been made aware. Licensed Practical Nurse Unit Manager #5 stated that Resident #170 should always be in a supervised area due to falls and verbal/physical behaviors. Licensed Practical Nurse Unit Manager #5 stated that floor mats should not have been on the floor while Resident #170 was in their wheelchair. Licensed Practical Nurse Unit Manager #5 stated that Resident #170 would wander into their room, and when staff tried to redirect them, Resident #170 would become abusive and wanted to be left alone. Licensed Practical Nurse Unit Manager #5 stated that Resident #170 should have been on 15-minute checks and would be implementing the 15-minute checks. During an interview on 08/20/24 at 10:00 AM, the Director of Nursing stated Resident #170's floor mats should be out of the way and not on the floor when the resident was in the wheelchair. The Director of Nursing stated that Resident #170 should not be left alone in their room due to falls and their history of verbal and physical behaviors against staff and their peers. 10 NYCRR 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observation, record review and interviews during the recertification survey from 8/13/2024 to 8/20/2024, the facility did not ensure that each resident received necessary respiratory care including oxygen therapy that was in accordance with professional standards of practice and as ordered by the practitioner for 1 (Resident #392) of 2 residents reviewed for respiratory care. Specifically, Resident #392 received oxygen for 4 days without a physician order. Findings include: Resident #392 had diagnoses which included dependence on supplemental oxygen, heart failure, and difficulty in walking. The Nursing Admission Evaluation, dated 8/12/24 at 10:08 PM, documented the resident had oxygen at 4 liters/minute by Nasal Canula/Mask, for chronic use. the most recent oxygen saturation was 95% on 8/12/24 at 10:20 PM and the resident was receiving oxygen by mask. During observations on 08/13/24 at 01:57 PM and 8/14/24 at 1:45 PM Resident #392 was in their bed, wearing a nasal canula with a tube connected to the oxygen concentrator with 4-liter flow oxygen. The resident stated that they had been on the oxygen continuously since they were admitted to the facility. Review of the August 2024 Treatment Administration Record and physician orders on 8/15/24 at 04:02 PM revealed no documented order for the oxygen therapy. During interview on 08/19/24 at 11:51 AM, Registered Nurse #30 stated Resident #392 was on oxygen continuously via oxygen concentrator or oxygen tank. The surveyor and nurse reviewed the physician orders and the Treatment Administration Record. Registered Nurse #30 observed the start date for the oxygen was 8/16/24 and stated they did not know why there was no order when the resident was admitted on [DATE]. 10 NYCRR 415.12(k) (6)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47626 Based on observation, record review, and interview during the recertification survey conducted 8/12/2024-8/20/2024, the facility did not ensure residents who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services received such services consistent with professional standards of practice for 1 of 1 resident (Resident #127) reviewed for Dialysis. Specifically, Resident #127 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments. Additionally, there was not consistent ongoing communication and collaboration between the facility and the dialysis center. Findings include: A Policy and Procedure dated 6/23/2023 titled Hemodialysis documented: the facility will establish a communication book which will include any pertinent information on the resident, such as vital signs, including blood pressure and site used to take the blood pressure, medications given prior to dialysis, any lab values done here, any new deleted medication, and any significant changes since last dialysis treatment. Resident #127 had diagnoses including end stage renal (kidney) disease, dependence on renal dialysis, and Type 2 Diabetes. The 7/10/2024 Minimum Data Set (an assessment tool) assessment documented the resident was cognitively intact and required hemodialysis treatments. The Comprehensive Care Plan initiated 12/08/2022 documented the resident needed dialysis related to end stage renal disease. Interventions included to check dressing daily at access site, change dressing only if ordered by the physician, document condition and complications, and use of communication book between facility and Renal Care Center. The 4/2/2024 physician order documented the resident was to attend dialysis on Tuesday, Thursday, and Saturday; and to check the access port every shift. The resident's dialysis communication book did not include documentation of pre-dialysis or post-dialysis vital signs, weights, or evaluation of the dialysis access site or a signature for the documentation. There were no forms to document dialysis evaluation for 8/8/24, 8/10/24, or 8/13/24. During an observation and interview on 8/14/2024 at 9:10 AM Resident #127 was in bed and stated dialysis had been going so, so. The resident stated that they could not tolerate the whole treatment and had left the treatment early. During an interview on 08/15/24 at 12:13 PM, Licensed Practical Nurse #8 stated they should initiate a communication form to include information on any changes in the residents medication and vital signs. When the resident went to dialysis they should have put the form in the communication book that the resident took to dialysis. The dialysis center should be completing the pre and post weights and vital signs. Licensed Practical Nurse #8 stated they did not know why the forms were not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/24 at 12:33 PM, the Dialysis Center Staff stated they used communication books for nursing home residents and sometimes the books got lost. The dialysis staff should be completing the section including vital signs and weight pre and post dialysis. They also stated that even if the facility did not send the form with the resident, the information should still be provided. During an interview on 08/16/24 at 08:52 AM, the Assistant Director of Nursing stated we should be communicating with the dialysis regarding the resident. The nurse on the unit should fill out the communication form which includes information about the residents' allergies, vital signs, a description of the arterial venous site and any medications given. The form should be placed in the dialysis book that goes with the resident to the dialysis center. The staff at dialysis then complete the form with pre and post weight, the amount of fluid removed, labs drawn, vital signs, and any comment as needed. The Assistant Director of Nursing stated they did not know why it was not completed. 10NYCRR 415.12(k)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49255 Based on record review and interview conducted during the recertification survey from 8/13/24 to 8/20/24, the facility did not ensure certified nurse aide performance reviews were completed at least once every 12 months. Specifically, performance reviews were not documented every 12 months for 4 of 5 certified nurse aides reviewed (Certified Nurse Aide #9, #10, #11, and #12). The findings are: The facility policy titled Human Resources Section: Performance Evaluations revised 9/11, documented it is the facility policy to conduct a periodic evaluation of each employee's performance in relation to those standards. Formal written performance reviews are conducted at the end of the probationary or orientation period, and at least annually thereafter. Primary supervisors are responsible for evaluating the work performance of their employees. When requested on 8/16/24, the facility was unable to provide documented evidence that Certified Nurse Aides #9, #10, #11, and #12 had performance reviews completed at least once every 12 months. During an interview on 08/16/24 at 11:59 AM, the Director of Clinical Operation stated annual performance reviews for Certified Nurse Aide #9, #10, #11, and #12 were not completed. 10NYCRR 415.26 (c)(1)(IV)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 8/13/24 to 8/20/24, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for two of five residents (Residents #170, and #90) reviewed for unnecessary psychotropic medications. Specifically, (1) Resident #170 who was admitting to the facility on [DATE] with a diagnosis of Dementia who had been receiving the antipsychotic Quetiapine(Seroquel) since admission, had no clinical rationale for use of the antipsychotic, had no psychiatric evaluations or follow ups, no documented evidence of behavioral monitoring, and no attempts at a gradual dose reduction in the absence of clinical symptoms. (2) Resident #90 had their medications reviewed by the Pharmacist Consultant on 7/24/24 with recommendations to taper Risperidone 0.25mg from twice a day to once a day, and although the Physician agreed with the Pharmacist Consultant's recommendations, the recommendation were never carried out by the facility. The finding are: The facility policy titled Drug Regimen Review dated 9/2018 documented that the purpose is to ensure that all residents admitted and readmitted to the facility have the prompt availability of Drug Regimen Review services, for purposes of rapidly identifying and communicating to the facility opportunities to discontinue potentially unnecessary medications. In addition, Drug Regimen Reviews for newly admitted and readmitted residents provides the potential to correct any errors that may have occurred during the transition into the care of the facility. The Prescriber/Licensed Designee shall act upon clinically significant or urgent Drug Regimen Review findings by midnight of the next calendar day and act all other Drug Regimen Review findings/recommendations in a timely manner of 30 days or less. The facility policy titled Psychotropic Medications dated 10/2018 and revised on 05/2023 documented that it is the policy of this facility to provide each resident with appropriate assessment and intervention regarding use of psychoactive medications to achieve the highest practicable level of independence for the resident. The use of psychoactive medications is monitored and evaluated, and residents are assessed for reduction opportunities on an ongoing basis. New admissions will be evaluated for the use of psychoactive medications (anti-depressants, anti-psychotics, sedatives/hypnotics, and anti-anxiety agents). Residents admitted to the facility on psychoactive medication will be evaluated after 14 days for possible dose reduction. 1. Resident #170 was admitted on [DATE] with diagnoses including but not limited to dementia with unspecified severity, dementia without behavioral disturbances, dementia without psychotic disturbances, and dementia without mood disturbances or anxiety. The 5/16/24 5-day Minimum Data Set documented that Resident #170 had severely impaired cognition. Resident #170 received antipsychotic's, had no psychiatric/mood disorders, and no issues were identified during the drug regimen review. (continued on next page)

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	335440	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Poughkeepsie Ctr for Nursing & Rehab	100 Franklin Street Poughkeepsie, NY 12601

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/10/24 physician order documented to administer a Quetiapine Fumarate(Seroquel) 25 milligrams at bedtime for a diagnosis of dementia. The 5/10/24 physician order documented a Psychiatry Consult as needed for evaluation and treatment as indicated. The Psychotropic Medication use care plan dated 5/10/24 documented Resident #170 used psychotropic medications. Interventions included to administer psychotropic medications as ordered by physician, and to monitor for side effects and effectiveness. Drug Regimen Review dated 5/13/24 the Pharmacist Consultant documented that Resident #170 was recently admitted on Seroquel for behaviors associated with dementia, therefore the facility should consider obtaining psychosocial workups along with performing medical workups as soon as possible to assess for underlying causes of behaviors, and if the workups and nursing behavioral monitoring reveal no significant behaviors or identification of a chronic psychiatric condition, the facility should consider implementing a tapering schedule and/or discontinuance of the Seroquel. The Primary Nurse Practioner disagreed with the Pharmacist Consultant's recommendation and documented behavior, follow up psych. Review of the electronic medical record revealed no documented evidence of behavioral monitoring, a psychiatric evaluation or consideration of a gradual dose reduction from 5/13/24 to 8/14/24. A Physician Progress note dated 8/15/24 at 4:12 PM by the Psychiatric Nurse Practitioner Consultant documented that Resident #170 was admitted to the facility on Seroquel with a diagnoses of Dementia, and that Resident #170 had some behaviors including spitting and hitting at staff. The recommendations was to discontinue Seroquel due to no Federal Drug Administration indication for its use. No evidence of psychosis, mania, or delusions, and to continue to manage behaviors with nonpharmacological interventions currently. The 8/16/24 physician order documented discontinuance of Quetiapine Fumarate(Seroquel) 25 mg at bedtime for a diagnosis of dementia. During an interview on 08/16/24 at 04:26 PM, the Medical Director stated that Resident #170 was admitted to the facility on Seroquel and should not have been on Seroquel with diagnosis of Dementia and no clinical rationale for the medication. The Medical Director stated that Resident #170 should have had a psychiatric evaluation as soon as possible after admission. The Medical Director stated that Resident #170 was seen by the Psychiatric Nurse Practitioner Consultant on 8/15/24, in which the Psychiatric Nurse Practitioner Consultant gave recommendations to discontinue the Seroquel. The Medical Director stated that prior to 8/15/24, Resident #170 did not have any Psychiatric evaluations done, and had they had a Psychiatric evaluation done, the Seroquel could have been discontinued earlier. During an interview on 08/19/24 at 02:39 PM, the Psychiatric Nurse Practitioner Consultant stated that on 8/14/24, they were contacted by the Medical Director to evaluate Resident #170 for the use of Seroquel and the diagnosis of dementia. They stated prior to 8/14/24, they had no knowledge of Resident #170. The Psychiatric Nurse Practitioner Consultant stated that Resident #170 was evaluated on 8/15/24 with recommendations to discontinue Seroquel due to no Federal Drug Indications for its use, and no evidence of psychosis. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/20/24 at 10:00 AM, the Director of Nursing stated that when a resident was on an antipsychotic, nurses should be writing behavior notes and behavioral monitoring. The Director of Nursing stated that Resident #170's physically and verbally aggressive behaviors should have been monitored by nursing staff, and that nurses should have communicate with physicians about the resident's behaviors and documented in progress notes. Surveyor : [NAME], [NAME] 2. Resident # 90 was admitted to the facility with diagnoses including Dementia, Psychosis, and Major Depression. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 5/17/2024 documented a the resident was severely cognitively impaired, and received anti-psychotic medication for psychosis. The facility physician's orders, dated 2/13/2023, documented Risperdal 0.25 milligram tablet, give one tablet by oral route two times per day for a diagnosis of Psychosis. The psychiatric consultation report, dated 2/26/24, documented Resident #90 had been stable with no behavior issues, appetite good and sleeps through the night. Resident# 90 was alert, oriented x 2, no signs or symptoms of mania, no signs or symptoms of psychosis, no evidence of delusions, paranoid thinking, and behavior. Psychiatrist medications included Risperdal, Elavil, Nomenda, and Lexapro. The plan was to continue medications as ordered in the management of depression and anxiety. Resident #90 medication regimen was reviewed by the Pharmacist Consultant , drug regimen report dated 7/24/2024, documentation on the resident currently receiving Risperidone 0.25 mg twice daily for behaviors associated with Dementia. No recent behavior problems noted. Please evaluate current dosing, consider trial taper to 0.25 mg daily, or document inability to do so. The physician signed off in agreement with a note with a note will follow up with psych. Further review of the medical record revealed no documented evidence that the physician followed through on the pharmacy report or had spoken with the resident's family. Resident #90 continued to received Risperidone 0.25 mg oral tablet two times daily as documented on Resident #90's August 2024 Medication Administration Record with last dose given to Resident #90 on 8/17/2024 at 9:00 AM. Resident #90 was transferred out to the hospital on 8/17/2024 at 3:18 PM. On 8/19/2024 at 11:33 AM, an interview with the Director of Nursing stated drug regimen review should take 1 week or 2 weeks for follow-up from the Physician or Nurse Practitioner. On 08/19/2024 at 2:50 PM, an interview (by telephone) with Psychiatrist Nurse Practitioner Consultant, they stated they did not receive the facility's drug regimen reviews. They stated it was the facility's responsibility to follow-up on the Pharmacist Consultant recommendations. 10 NYCRR 483.45(e)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from [DATE]-[DATE], the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. Specifically, the walk-in refrigerator contained unlabeled, undated, and expired food products. The dry storage pantry contained expired and undated food products. Two employees were observed not wearing hair restraints, and one employee was leaning over dessert items with their apron touching items while they were wrapping the dessert items with cling wrap. The Refrigerator and Freezer Temperature Logs were not being documented twice a day, and the walk in freezer had areas of ice accumulation on floor. The findings are: The facility policy titled Storage of Food and Supplies revised ,d+[DATE] documented that food, non-food items, and supplies used in food preparation and service shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as outlined in the Federal Drug Administration food code, state regulations, and city/county health codes. Food products that are opened and not completely used; transferred from its original package to another storage container, or prepared at the facility and stored should be labeled as to its contents and used by dates. Discard food that exceeds their use-by date or expiration date, that is damaged, and is spoiled. The facility policy titled Personal Hygiene for Food Handlers revised ,d+[DATE] documented that individuals who handle food, practice good personal hygiene to minimize the risk of contaminating food that can result in a foodborne illness. Aprons are changed when soiled. Hair Restraints such as hats, hair coverings or nets, and beards restraints are always worn when in the kitchen, and hair is to be fully contained inside the covering. Facial hair is to be completely trimmed and cover by a mask or a beard guard. The facility policy Monitoring Refrigerator /Freezer Temperature revised ,d+[DATE] documented to check and record temperature readings on a designated log for refrigerators and freezers at least twice daily (AM and PM), and foodservice is responsible for monitoring cold storage of food in the foodservice kitchen and nourishment kitchen and nourishment kitchen(S). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an initial tour of the kitchen on [DATE] at 09:58 AM, the following was observed in the Walk in Refrigerator: a metal container containing cooked white rice that was undated and unlabeled, a metal container containing 8 undated and unlabeled cooked beef burgers, approximately 15 single serve containers of ice cream, 3 undated individual servings of side salads on a cart, a metal container containing unlabeled cooked chicken burgers that was dated [DATE], 3 undated individual servings of side salads on a cart, an undated box labeled cooked chicken patties that was thawed on shelf and not kept frozen as per box instructions, sliced undated and unlabeled turkey deli meat wrapped in cling wrap, a clear unlabeled storage container on the shelf containing a tomato sauce dated [DATE], a box of approximately 15 packages of tortillas that expired on [DATE], an undated when opened gallon of 2% milk, a half a box of uncooked, defrosted seasoned beef patties with directions to keep frozen, 3 boxes of imitation crab meat defrosting in refrigerator that was labeled keep frozen with no expiration dates on boxes, one undated opened bag of slaw mix that showed signs of deterioration, undated open box of sausage patties defrosting in refrigerator with instructions on box to keep frozen, an opened undated box of bagged 5 pound lettuce/salad mix, two 5 pounds containers of expired cottage cheese with expiration date of [DATE], approximately 2 cups of undated and unlabeled shredded cheese in a metal storage container, a turkey sandwich on wheat bread dated [DATE], a metal storage container containing expired and unlabeled sliced deli ham that was dated [DATE], an opened undated 20-pound container of precooked hard-boiled eggs, an opened Westcreek Whole Milk Blue cheese dressing with no expiration date or date when opened on container, approximately 10 Cheese slices undated and unlabeled on a paper plate, one unopened 6 pound can of tapioca pudding expired [DATE]. There were no evening shift temperatures documented on the temperature logs from [DATE]-[DATE]. On [DATE] at 10:00 AM during an initial observation of walk in freezer five golf ball sized lumps of ice were observed on the floor. On [DATE] at 10:05 AM during the initial tour of the kitchen, the [NAME] was observed wearing a baseball hat with their hair protruding from sides and back if hat onto the back of their neck. On [DATE] at 10:09 AM, Dietary Aide #7 was observed leaning over orange frosted cakes while preparing the cakes and apron was visibly soiled. On [DATE] at 10:09 AM, Dietary Aide #27 was observed with hair on their face and head and was not wearing a hair net or facial covering. On [DATE] at 12:27 PM, during an observation of the 3rd floor nourishment pantry, the [DATE] PM shift temperature log documented a temperature of 49.1 degrees Fahrenheit. On [DATE] at 10:00 AM, an opened undated 50 pound bag of [NAME] brand red potatoes was observed in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:00 AM during observations of the Dry Storage Pantry, a two pound bag of undated when opened Tasty O's Crispy rice cereal, an undated when opened [NAME] Brand ziti pasta, an undated when opened expired 4 pound bag of egg noodles 4 pound bag with an expiration date of [DATE], an expired 15.1 ounce bottle of [NAME] Raspberry Dessert Sauce with an expiration date of ,d+[DATE], an undated when opened expired 5 pound bag of R&F brand elbow noodles with an expiration date of [DATE], three undated when opened containers of French's mustard, an undated when opened five pound bag yellow cake mix, an updated when opened expired container of McCormick's Whole Dutch Poppy Seed seasoning with an expiration date of [DATE], opened undated English muffins opened, an opened undated bag of whole wheat bread, crumbs from the toaster that fell on food products below (pancake syrup, bottles of lemon juice) and on to the floor of the pantry. On [DATE] at 10:00 AM during an observation of the three-month emergency supply room, there were three-day menus present without approved by signatures or dates. During an interview on [DATE] at 9:58 AM, the Assistant Director of Food Services stated that food items that are opened should be labeled and dated with an opened date. The Assistant Director of Food Services stated that food items should not be expired. The Assistant Director of Food Services stated that they will dispose of all the undated, not labeled, and expired food items in the kitchen. During an interview on [DATE] at 10:09 AM, Dietary Aide #27 stated that they were aware that they were supposed to wear a hair net and beard covering while in the kitchen. During an interview on [DATE] at 5:03 PM, the Director of Food Services stated that the Director and Assistant Director of Food Services were responsible for ensuring kitchen staff were wearing hair restraints and ensuring that kitchen staff did not lean over food during food preparation. They said in-services were conducted to address hair restraints and kitchen staff hygiene. The Director of Food Services stated that all kitchen staff should always wear hair restraints and wear clean aprons. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 5:03 PM, the Director of Food Services stated all kitchen staff were responsible for dating food products when initially opened and for labeling all food items stored in the walk in refrigerator, walk in freezer, dry pantry, and three-month supply room. The Director of Food Services stated that they oversaw the kitchen to ensure the three-day expiration policy was followed. Director stated all food products should be labeled and dated when opened, expiration dates should be on products and discarded according to expiration date. The Director of Food Services stated that they, or the Assistant Director, perform daily rounds of refrigerator, freezer and dry storage and discard products that are not labeled and/or dated. The Director of Food Services stated that food deliveries are on Mondays and Thursday, and that the dietary aide who was assigned to unloading deliveries was responsible for organizing the stock, rotating products, and checking for delivery date and expiration dates. The Director of Food Services stated that they, or the Assistant Director of Food Services were responsible for supervising dietary aides and ensuring they were following policy and procedure. The Director of Food Services stated that the Cooks were responsible for completing temperature logs for the refrigerator and freezer twice a day and dietary aides assigned to daily unit pantry deliveries were responsible for conducting and documenting temperatures checks twice a day. The Director of Food Services stated that temperatures outside of acceptable ranges should be reported to Director or Assistant Director of Food Services. Director of Food Services stated that a newly promoted cook was responsible for refrigerator and freezer temperature checks and documentation for dates [DATE]-[DATE]. The Director of Food Services stated they were aware that the outside thermometer for the refrigerator needed repair for several months and that they submitted a repair request on [DATE]. The Director of Food Services stated that the floor in walk-in freezer should not contain ice and that ice was likely due to condensation and humidity due to the freezer door being opened during deliveries. 10NYCRR 415.14(h)