STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335447	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Street Home Inc	787 King Street Port Chester, NY 10573

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 49372 Based on record review and interviews during an abbreviated survey (NY00349278), the facility did not ensure the resident's legal representative was provided with a copy of the resident's medical records upon request and 2 working days advance notice to the facility for 1 out of 3 residents (Resident #1) reviewed for medical records. Specifically, Resident #1's legal representatives requested the medical records for Resident #1 via email to the facility administrative coordinator on 8/23/2024. Resident #1's legal representative did not receive requested medical records until 9/10/2024, twelve days after the request was received by the facility. In addition, review of the facility policy revealed it did not meet federal regulations The findings are: The facility Access to Medical Records policy last reviewed January 2024 documented it is the policy to only allow the resident and/or legal representatives access to his/her medical records. All other requests to view a resident's medical record will be declined unless legal documentation is obtained, or a representative of the Department of Health makes the request. All requests must be made in writing. If a copy of the medical record is requested by the resident and/or legal representative, a copy will be provided within 7 to 10 business days. Review of an email correspondence from Resident #1's representative to the Administrative Coordinator revealed a request for the resident's medical records was submitted on 8/23/2024 at 8:47 AM. Review of an email correspondence to Resident #1's representative revealed the administrative coordinator sent the requested records to the representatives on 9/10/24 at 4:41 PM. During an interview on 2/13/2025 at 11:35 PM, the Administrative Coordinator stated they are responsible for completing medical record requests. The Administrative Coordinator stated medical records were requested via email by 2 of Resident #1's representatives, and they both requested the same documentation multiple times. The Administrative Coordinator stated they provided the medical records electronically to Resident #1's representative on 9/10/24 and they also provided a hard copy upon request. The Administrative Coordinator stated when they receive a release form, the documents are provided to the requestor within seven to ten business days as stated on their form. The Administrative Coordinator stated the facility does not use the Health Information and Portability and Accountability Act official request form and that this form was developed by the facility prior to them working here. (continued on next page)

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

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2025 at 4:00 PM, the Assistant Administrator stated the medical record request form is completed by the resident, or the family and records can be requested from any staff member, but the Administrative Coordinator is the one responsible to complete the request and there is no fee associated with receiving electronic copies of medical records. The Assistant Administrator stated they were only aware of the seven to ten business day turnaround time for receiving requested medical records and they were not aware of any other timeframe. 10 NYCRR 415.3(d)(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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 49372 Based on record review, observations and interviews during an abbreviated survey (NY00349278) the facility did not ensure postings were in a form and manner accessible and understandable to residents, resident representatives a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation. Specifically, during the on-site visit there were no posting of the information above observed throughout the facility, accessible to residents or resident representatives. The findings are: During an observation on 2/11/2025, there were no visible postings of contact information of pertinent State agencies or advocacy groups. There was a glass encasement in an alcove by the Assistant Administrators office with the staffing schedule posted as well as the wound care company utilized by the facility and the contact information for the Office of long-term care Ombudsman program. In the elevators there were also posters for the contact information and process for the Office of long-term care Ombudsman program. There were no additional postings observed throughout the facility Review of the visitor sign in logbook on 2/12/2025 revealed a stack of visitor log in forms separated by a tab that stated companion. Below the tab were additional login forms and other documents in sheet protectors including: New York State Department of Health complaint hot line number, the Ombudsman hotline number, the Residents [NAME] of Rights and the results of the most recent New York State Department of Health survey results from 1/11/2024, Facility Licenses and Registrations, private bed hold policy and various informational posters laminated. None of the information was posted and accessible to the residents or their representatives. During an interview on 2/11/2025 at 11:50 AM, the Assistant Administrator stated they have the Department of Health complaint number posted in the survey book at the front desk and the number is also included in the admission packet with the email address to the Department of Health. The surveyor informed the Assistant Administrator there are no resident rights posted within the facility. The Assistant Administrator stated they believe it is posted in the glass encasement with the Ombudsman information. The Surveyor did not observe the residents right posted in glass encasement during the onsite survey. 10 NYCRR 415.3(d)(2)(i)(b)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49372 Based on observations, record review, and interviews during an abbreviated survey (NY00349278), the facility did not ensure the results of the facilities most recent New York State Department of Health survey were posted in a place readily accessible to residents, and family/legal representatives of residents. The facility also did not have a posted notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. Specifically, the surveyor did not observe any results posted anywhere in the facility regarding the most recent survey conducted by the New York State Department of Health. The findings are: The facility Posting Survey Information policy last reviewed August 2024 documented it is the policy to comply with New York State Department of Health regulations by posting the results of the most recent Certification Survey in a location that is readily accessible to residents, their families, and other interested parties. Review of the visitor sign in logbook revealed a stack of visitor log in forms separated by a tab that stated companion. Below the tab were additional login forms and documents in sheet protectors including: New York State Department of Health complaint hot line number, Ombudsman hotline, Residents [NAME] of Rights and the results of the most recent New York State Department of Health survey from 1/11/2024. The facility Licenses and Registrations, private bed hold policy and various informational laminated posters laminated were also found. During an interview on 2/11/2025 at 11:50 AM, the Assistant Administrator stated they have the Department of Health complaint number posted in the survey book at the front desk and they also include the Department of Health complaint number in the admission packet with the email address to the Department of Health. The Assistant Administrator stated they will be including the postings to the information within the glass enclosures on the units and in the elevator next to the Ombudsman contact information/posters. During an interview on 2/11/2025 at 3:35 PM, the Receptionist stated they have been working in the facility for a year now. The Receptionist stated the New York State Department Health survey results are in the back of the visitor sign in logbook and if they are not asked for the results then a visitor would never know they were there. During an interview on 2/12/2025 at 9:30 AM, the Director of Nursing stated they were unaware of where the results from the last completed Department of Health Standard Recert Survey was located. 10 NYCRR 415.3(d(1)(v)

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00349278), the facility did not ensure the residents right to personal privacy and confidentiality of his or her personal and medical records for 1 out of 3 residents (Resident #5) reviewed for confidentiality. Specifically, on 1/14/2025 Resident #1's representative requested medical records which they forwarded to Resident #1's physician. Resident #1's representative was informed by Resident #1's physician's office that they had received medical records for Resident #5 instead of Resident #1. The Administrative Coordinator stated Resident #5's care plans were sent to the physician office in error. The findings are: The facility undated Resident's [NAME] of Rights policy documented it is the policy that each resident is treated with consideration, respect and in full recognition of his/her dignity and individuality, including privacy. Each resident shall enjoy the right to confidential treatment of personal and medical records. 1) Resident #1 had diagnoses including but not limited to Vascular Dementia, Cardiomyopathy and Mood [Affective] Disorder. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted. Resident #1 had no impairments to the upper or lower extremities and did not utilize any assistive devices. The resident required set up for meals and was dependent for toileting, bed mobility and transfers. 2) Resident #5 had diagnoses including but not limited to Dementia, Major Depression and Pulmonary Embolism. A Comprehensive Minimum Data Set, dated dated dated [DATE] documented Resident #5 had severe cognitive impairment. Resident #5 required a wheelchair for locomotion was dependent for eating, toileting and transfers and required maximal assistance with bed mobility. Review of an email correspondence from Resident #1's representative to the Administrative Coordinator on 1/14/2025 at 11:34 AM revealed Resident #1's representative received Resident #5's care plans in the medical records received instead of Resident #1's care plans. Resident #1's representative informed the Administrative Coordinator that Resident #1's primary care physicians office noticed an error in the medical records received that required immediate attention. Review of an email correspondence from the Administrative Coordinator to Resident #1's representative on1/14/2025 at 12:46 PM revealed the Administrative Coordinator acknowledged the error and was grateful to Resident #1's representative for bringing the error to their attention and resent the correct documentation for Resident #1. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 1:35 PM, the Administrative Coordinator stated they sent Resident #1's representatives Resident #5's care plan by accident as they were being rushed to send the documentation before 4 PM. The Administrative Coordinator stated they were in a hurry, compiled and sent the documents with Resident #5's information. The Administrative Coordinator stated the email with the Resident #5's care plan was sent on 1/10/2025 and the correct documentation requested was sent to Resident #1's representatives on 1/14/2025. The Administrative Coordinator stated the error occurred only one time with Resident #1's family. 10 NYCRR 413.3(e)(1)(ii)

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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** 49372 Based on observation, record review, and interviews during an abbreviated survey (NY00349278, NY00364670) , the facility did not ensure residents/resident representatives were notified through postings in prominent locations throughout the facility of the right to file grievances orally or in writing; the contact information of the grievance official with whom a grievance can be filed, a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency or protection and advocacy system; or ensuring that all written grievance decisions include a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued for 1 out of 4 residents (Resident #1) reviewed for grievances. Specifically, the facility provided grievance reports filed by Resident #1's representative daily for the months of January 2024, March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, September 2024, October 2024 and November 2024 with no specific resolution documented for the grievances. In addition, there was also no observed posting of who the facility grievance officer was, or the process residents/resident representatives needed to follow to file a grievance. The findings are: The facility Investigation of Grievances/Concerns policy last reviewed August 2024 documented the facility is committed to fair and equal treatment of all residents and will complete a prompt, thorough investigation of all grievances and/or concerns filed with the facility. Concerns may include but are not limited to care issues, issues of alleged discrimination and customer service concerns. Concerns/grievances may be filed orally or in writing. The resident/resident representatives/person acting on behalf of the residents will be informed of the findings of the investigation, as well as any corrective actions recommended within 15 working days of the filing of the grievance/concern. A copy of the grievance/concern form will be filed in the resident's grievance binder located in the social services office. Concerns and grievances will be monitored for pattern and trend and will be reported regularly at the Quality Assurance and Performance Improvement committee meeting for additional corrective action/interventions. There was no observed grievance process information posted in the facility to inform the residents about the process of filing a grievance or who to contact. Resident #1 had diagnoses including but not limited to Vascular Dementia, Cardiomyopathy and Mood [Affective] Disorder. A Modification of Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted Resident #1 had impairment to their upper extremity on one side and used a walker or a wheelchair for locomotion. The resident required set up assistance for meals, maximal assistance with toileting and bed mobility and dependent for transfers. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written grievance report dated 12/17/2024 and submitted 12/18/2024, and 12/23/2024 by Resident #1's representative documented the type of grievance as follows: care/medical treatment, safety/hygiene, financial/billing and rights violation. Attached was a follow up grievance report dated 12/18/2024 documenting an investigation: chart and Certified Nurse Aide Accountability Report reviewed, discussion with nurses, certified nurse assistants, rehabilitation staff, dietician and social worker regarding plan of care and staff knowledge and ability to follow plan of care. The action documented met with family representatives in person and on phone as well as requested physician of Resident #1 to discuss plan of care and concerns. Resident #1's family representatives verbalized dissatisfaction with standard of care interventions and current individualized interventions. The resolution documented no resolution issues remain ongoing as expectations are unrealistic. Resident #1's representative on site daily and some days multiple visits with multiple discussions with staff to address their concerns/expectations in addition to multiple emails-consuming tremendous staff time that takes away from the other residents. Encouraged Resident #1's representative on multiple occasions to contact Ombudsman/Department of Health and offered to assist with finding another facility since needs cannot be met to satisfaction. Review of Resident #1's facility Grievance reports for January 2024, March 2024, April 2024, May 2024, June 2024, July 2024, August 2024, September 2024, October 2024 and November 2024 documented the nature of the grievances as follows: alleged abuse or neglect, billing/finance, care needs not met, delay/lack of physical care, dietary/nutritional needs, general dissatisfaction, medical care, medication, nursing care, rehabilitation, resident rights and staff attitude. All the reports documented the date as daily by Resident #1's representatives and received by the Assistant Administrator. The investigation on the reports documented discussion with the certified nurse assistant's, nurses assigned to Resident #1, rehabilitation and when appropriate Resident #1. The action and resolution documented review of menu and substitutions with the Dietician/certified nurse assistants and ongoing with Resident #1. The Director of Rehabilitation/Regional Director of Theradynamics handling Resident #1's representatives rehabilitation issues. The Director of Nursing/in-service coordinator continues education and support of staff. No resolution issues remain ongoing as expectations are unrealistic. Resident #1's representative on site daily and some days multiple visits with multiple discussions with staff to address their concerns/expectations in addition to multiple emails-consuming tremendous staff time that takes away from the other residents. Encouraged Resident #1's representative on multiple occasions to contact Ombudsman/Department of Health and offered to assist with finding another facility since needs cannot be met to satisfaction. A written grievance report was submitted on 2/8/2025 by Resident #1's representative documenting the type of grievance as follows: care/medical treatment, staff behavior and rights violation. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 10:12 AM, the Director of Social Services stated they were the only social worker in the building, and they are the facility grievance officer. The Director of Social Services stated they have been handling all of the grievances in the facility since November or December. The Director of Social Services stated Resident #1's representative usually completes the grievance form and emails it back and the form is sent to the respective departments involved. Resident #1's representatives are informed that the departments would conduct their investigation and get back to them with the findings. The Director of Social Services stated unless the department asks for their assistance, their involvement ends with the submission of the forms to the department heads. The Director of Social Services stated they do not keep track of the grievances and their resolutions, but they are informed of the outcomes. The Director of Social Services stated the grievances are maintained by the Assistant Administrator. The Director of Social Services stated they have only received one grievance form since the new policy became effective which was from Resident #1's representative. The Director of Social Services stated for Resident #1 there is only one official documented grievance form completed by Resident #1's representatives as most of the time they emailed with their issues to be addressed. The Director of Social Services stated they have to double check if there is a posting about the grievance process and the steps for the resident to take if they have a grievance in the facility. The Director of Social Services stated they think there is a posting in the box where the Ombudsman information is located on the [NAME] and East units. The Director of Social Services stated they do not believe they documented a note regarding the grievance they handled, and they would have to go back and check. The Director of Social Services stated the grievance information is not posted by their office because there is no place to hang the information. At 10:53 AM the Director of Social Services returned with the grievance book and stated the grievance that was sent to them from Resident #1's representative was dated 12/16/2024. The Director of Social Services stated it is an ongoing process, the grievances that states no resolution mean the family is not in agreement with the resolution. During an interview on 2/12/2025 at 9:25 AM, the Assistant Administrator stated they are having problems with Resident #1's representative and showed the surveyor 3 binders of email correspondence between them and the facility. The Assistant Administrator stated at this point they are unsure of what to do regarding Resident #1's representatives. They do not have an issue with Resident #1 and can provide them with the care they need, but they do not know what to do about the resident's representatives. The Assistant Administrator stated they have swapped all the staff on the units due to Resident #1's representatives making allegations about staff. The Assistant Administrator stated they have scheduled care plan meetings in which nothing gets accomplished because Resident #1's representative become hostile and dismisses team members from the meeting stating they do not want them at the meeting, including the Director of Nursing and many other team members. The Assistant Administrator stated there are no resolutions for the grievances reported by Resident #1's representative because they are never satisfied or agree with the interventions presented to them. 10 NYCRR 415.3(d)(1)(i)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00349278) the facility did not ensure the Minimum Data Set assessment accurately reflected the resident's status for 1 out of 4 residents (Resident #1) reviewed for assessments. Specifically, review of Resident #1's Minimum Data Set assessments dated 8/21/2024, 9/30/2024 and 12/17/2024 revealed discrepancies regarding the resident's extremity impairments, use of assistive devices and functional abilities. The Findings are: The Facility Completion of the Resident Assessment Instrument (RAI) Process policy last reviewed January 2024 documented the policy assures that all residents achieve their highest level of functioning possible in maintaining their sense of individuality. Assessments will be completed within the guidelines outlined in the Resident Assessment Instrument Manual and include the Care Area Assessment and care planning processes to lead to the development of a plan of care to address and monitor each residents needs and function, and to track changes in the resident's status. Supporting documentation for the Resident Assessment Instrument process will be completed utilizing Center for Medicare and Medicaid Services requirements of the RAI process to support the coding of the Minimum Data Set. Resident #1 was admitted with diagnoses including but not limited to Vascular Dementia, Cardiomyopathy and Mood [Affective] Disorder. A Modification of Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted. Resident #1 had impairment to their upper extremity on one side and used a walker or a wheelchair for locomotion. The resident required set up assistance for meals, maximal assistance with toileting and bed mobility and dependent for transfers. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. The resident exhibited rejection of care daily behaviors. Resident #1 had impairment on one side to their upper and lower extremities and used a wheelchair for locomotion. The resident required set up assistance for eating was dependent for toileting, bed mobility and transfers. An Annual Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment. The resident exhibited verbal behavioral symptoms directed towards others. The resident had impairment on one side to the upper extremity. The resident required a wheelchair for locomotion. The resident required set up assistance with meals and was dependent for toileting, bed mobility and transfers. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted. Resident #1 had no impairments to the upper or lower extremities and did not utilize any assistive devices. The resident required set up for meals and was dependent for toileting, bed mobility and transfers. Review of Resident #1's Minimum Data Set assessments revealed the following discrepancies: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Modification of Quarterly dated 5/26/2024 documented impairment upper extremity on one side, using walker or wheelchair for locomotion with maximal assistance needed for toileting and bed mobility, dependent transfers -Quarterly dated 8/21/2024 documented impaired upper and lower extremities on one side and dependent for toileting, bed mobility and transfers -Annual dated 9/30/2024 documented impairment on one side upper extremity. Using a wheelchair for locomotion and dependent for toileting, bed mobility and transfers -Quarterly dated 12/17/2024 documented no impairments to upper or lower extremities and no assistive devices used for locomotion. During an interview on 2/13/2025 at 11:05 AM, the Minimum Data Set Coordinator Registered Nurse stated the information on the Minimum Data Set assessments dated 8/21/2024, 9/30/2024 and 12/17/2024 were incorrect and Resident #1 has a wheelchair and that has not changed. The Minimum Data Set Coordinator Registered Nurse stated there was no need for a significant change assessment because this information is not accurate. The Minimum Data Set Coordinator Registered Nurse stated they oversee the completion of the Minimum Data Set, but each department is responsible for completing portions on the Minimum data set. The Minimum Data Set Coordinator Registered Nurse stated they do not have time to review all areas of the assessment as it is unrealistic. The Minimum Data Set Coordinator Registered Nurse stated looking back to see the comparison of the assessments this should have been caught, especially for the areas completed by the same person. The Minimum Data Set Coordinator Registered Nurse stated they sign off that all areas are complete. Each department is signs off on the sections they complete as accurate. The Minimum Data Set Coordinator Registered Nurse stated the error on the 8/21/2024 and the 9/30/2024 Minimum Data Sets were done by the Regional Director and the inaccurate information entered on the 12/17/2024 was done by the Director of Rehabilitation. The Minimum Data Set Coordinator Registered Nurse stated they will be completing a modification of the Minimum Data Sets assessments for the errors identified. During an interview on 2/13/2025 at 2:55 PM, the Director of Rehabilitation stated they are responsible for the GG and the O sections of the Minimum Data Set. The Director of Rehabilitation stated to complete the Minimum Data Set, they check to see if there have been changes from the previous assessment, speak with the nursing staff on the unit and the Minimum Data Set Coordinator. The Director of Rehabilitation admitted they coded no device was used for locomotion on Resident #1's Minimum Data Set, dated dated dated [DATE] and that was an error. They should have coded yes for wheelchair use. The wheelchair use however was coded accurately on the GG section. 10 NYCRR 415.11(b)

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King Street Home Inc	787 King Street Port Chester, NY 10573

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00364670), the facility did not ensure a comprehensive person-centered care plan was implemented for 1 out of 3 residents (Resident #2) reviewed for care planning. Specifically, on 11/16/2024 Resident #4 was diagnosed with pneumonia and was ordered to start on antibiotic and oxygen therapy. Review of Resident #2's care plans revealed there were no care plans initiated for pneumonia, antibiotic use or oxygen use. The findings are: The facility Care Plan Development and Implementation policy last reviewed 5/2023 documented a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of each resident are ongoing, and care plans are revised as information about the residents' conditions change. Resident #2 was admitted with diagnoses including but not limited to Difficulty in walking, Urinary Tract Infection and Raynaud's Syndrome. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment. No behaviors noted. The resident had impairment to the upper extremities on both sides and required a walker and a wheelchair for locomotion. The resident required moderate assistance with eating, toileting and transfers and dependent for bed mobility. The resident had shortness of breath or trouble breathing during exertion and when lying flat and used oxygen while in the facility. Review of Resident #2's physician's order dated 11/16/2024 documented oxygen therapy at two liters per minute via nasal cannula as needed for shortness of breath. Review of Resident #2's physician's order dated 11/16/2024 documented Amoxicillin-Potassium Clavulanate 875-125 mg 1 tablet by mouth every twelve hours for pneumonia for 13 administrations. Review of Resident #2's care plans revealed there were no care plans initiated for pneumonia, antibiotic use or oxygen use. During an interview on 2/14/2025 at 2:54 PM the Director of Nursing stated they just started working for the facility and are trying to adjust the process of updating the care plan,as they feel the system is not strong at this point and everyone just updates the care plans. The Director of Nursing stated they are also trying to hire nurse managers for the units who will generally maintain the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone on 3/27/2025 at 10:50 AM, the Minimum Data Set Coordinator Registered Nurse stated the unit nurses are responsible to initiate/update the residents care plans with changes as they occur. The Minimum Data Set Coordinator Registered Nurse stated they could not find care plans for pneumonia, oxygen and antibiotic use for Resident #2. The Minimum Data Set Coordinator Registered Nurse stated Registered Nurse #1 received and entered the orders and the treatments for Resident #2 and Registered Nurse #1 would be the one to update those areas on the care plan. During a telephone interview on 3/27/2025 at 11:00 AM, Registered Nurse #1 stated when they usually receive any new orders, they would update the care plans pertaining to the orders received. Registered Nurse #1 stated they did not receive the antibiotics orders for Resident #2, so they did not initiate a care plan for the treatment. Registered Nurse #1 stated they did receive the orders for the oxygen for Resident #2 and forgot to initiate the care plan for the oxygen use. Registered Nurse #1 stated Resident #2's oxygen care plans should have been initiated when the order was implemented. Registered Nurse #1 stated if they had initiated the care plans for use of oxygen, they would have noticed the antibiotic and the pneumonia care plans had not been initiated, and they would have initiate them. Registered Nurse #1 stated because they did not receive the orders for the antibiotics for the pneumonia diagnosis, they were not responsible to initiate the care plans. Registered Nurse #1 stated Registered Nurse #3 was the one who received the orders and should have initiated those care plans. During a telephone interview on 3/28/2025 at 12:26 PM, Registered Nurse #3 stated they do not recall Resident #2, and they would not initiate a care plan for their diagnosis or antibiotic use. Registered Nurse #3 stated the process is they get the medication order and inform the family of the new orders. Registered Nurse #3 stated the unit manager, or the day shift Registered Nurse #1 would be responsible for initiating/updating the care plan with the new orders. Registered Nurse #3 stated Registered Nurse #1 would be the designated person to follow up with the care plan initiation/updates. 10 NYCRR 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00349278), the facility did not ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 out of 4 residents (Resident #1) reviewed for care planning. Specifically, Resident #1's comprehensive care plans for medication refusals, physical aggression, social needs and nutritional problems were not reviewed and revised with the quarterly Minimum Data Set completed on 12/17/2024. The Findings are: The facility Care Plan Development and Implementation policy last reviewed 5/2023 documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set assessment. Resident #1 had diagnoses including but not limited to Vascular Dementia, Cardiomyopathy and Mood [Affective] Disorder. A Modification of Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted Resident #1 had impairment to their upper extremity on one side and used a walker or a wheelchair for locomotion. The resident required set up assistance for meals, maximal assistance with toileting and bed mobility and dependent for transfers. A Modification of Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had moderate cognitive impairment. No behaviors noted. Resident #1 had impairment to their upper extremity on one side and used a walker or a wheelchair for locomotion. The resident required set up assistance for meals, maximal assistance with toileting and bed mobility and dependent for transfers. Review of a potential/actual physical aggression care plan last revised 1/31/2025 documented Resident #1 exhibited aggressive behavior towards staff by scratching, punching and threatening staff. Resident #1 transferred to the hospital for evaluation secondary to extreme verbal and physical aggressive behaviors towards staff. Menacing and threatening to strangle staff. Review of a social needs care plan last reviewed 2/13/2025 documented Resident #1 was dependent on staff to meet social needs. Interventions listed included provide 1:1 in-room visits and activities if resident refuses to attend out of room events. Review of a nutritional problem care plan last reviewed 1/21/2025 documented Resident #1 was at risk for malnutrition, diet restrictions, variable intake, unrealistic meal requests. Interventions listed included provide and serve diet as ordered, provide diet education and answer all questions during time of visits. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 11:05 AM, the Minimum Data Set Coordinator Registered Nurse stated they have been working in the facility for [AGE] years. The Minimum Data Set Coordinator Registered Nurse stated they oversee the nurses to ensure the care plans are updated. The Minimum Data Set Coordinator Registered Nurse stated the nurses are instructed that with every incident or change, the care plan needs to be updated. The Minimum Data Set Coordinator Registered Nurse stated the Registered Nurses, and the Licensed Practical Nurses complete the care plan updates, the care plans are reviewed quarterly, and they should be updated as things are happening. The Minimum Data Set Coordinator Registered Nurse stated if there are no changes then a notation should be entered in the care plans stating there are no changes. The Minimum Data Set Coordinator Registered Nurse stated they review, and spot check the quarterly care plans and let the nurses know if they are not completed. The Minimum Data Set Registered Nurse stated they have revised and reviewed Resident #1's care plans, but they see what the surveyor is stating about not being able to see the updates. The Minimum Data Set Registered Nurse stated the care plans were reviewed by the interdisciplinary team constantly as there is always something going on with Resident #1's representatives. During an interview on 2/12/2025 at 9:25 AM, the Assistant Administrator stated the Nursing Supervisor, or the Minimum Data Set coordinator are responsible for updating and maintaining the residents care plans. The Assistant Administrator stated that each team member is also responsible for updating the care plans related to their areas. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey (NY00354758), the facility did not ensure residents were free from significant medication errors for 2 out of 3 residents (Resident #3, Resident #8) reviewed for medication. Specifically, (1) during Resident #3's discharge instruction on their medications with Registered Nurse #1 on 9/16/2024, their family representative alerted Registered Nurse #1 that two medications: Lexapro (an antidepressant) and Seroquel/Quetiapine Fumarate(anti-psychotic) were prescribed to the resident in error because the resident was never on those medications. Resident #3 had received the antidepressant (Lexapro 10 mg) from 9/4/2024 to 9/16/2024. Resident #3 also received the anti-psychotic (Seroquel 50 daily at bedtime) from 9/5/2024 to 9/16/2024; (2) Resident #8 who was receiving an antipsychotic (Seroquel 25mg x2 daily) had a psychiatry consult on 9/4/2024 and was ordered for their antipsychotic to change to Seroquel 50 mg daily at bedtime. The change was not initiated until 9/11/2024. In addition, Resident #8 was also recommended for a dose reduction of their antidepressant (Lexapro 20mg daily to Lexapro to 10 mg daily) during the psychiatry consult on 9/4/2024. There was no documented evidence in the September Medication Administration Record that the recommended change was not initiated between 9/4/2024 to 9/19/2024. The findings are: The Facility Physician Medication Orders policy last reviewed August 2024 documented the purpose is to ensure the safe and effective ordering, administration and documentation of medications for residents in compliance with New York State regulations and facility standards. All medication orders must be written, reviewed, and administered in accordance with federal and state regulations and facility protocols to ensure resident safety and optimal therapeutic outcomes. Verbal orders are only accepted in emergencies and must be documented immediately by the nurse receiving the order and signed by the physician within 24 hours. Medication orders must be documented in the resident's medical record, including any changes or discontinuations. 1) Resident #3 was admitted to the facility on [DATE] with diagnoses including but not limited to Myocardial Infarction, Anxiety Disorder and Adjustment Disorder. A Modification of Admission Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact. The resident used a walker or a wheelchair for locomotion. The resident required set up assistance with meals, moderate assistance with toileting, bed mobility and transfers. Review of the facility report submitted to the New York State Department of Health documented that on 9/16/2024 during Resident #3's discharge from the facility Registered Nurse #1 was reviewing the discharge medications with Resident #3's representative and it was discovered that the psychotropic medication orders for Resident #3 were ordered in error. Investigation was immediately commenced, and findings reveal that the two psychotropic medication orders were intended for another resident with a similar last name. The facility's immediate response was for the Registered Nurse to assess Resident #3 and was noted to be stable, with no adverse reactions. The Psychiatric Nurse Practitioner #1 was notified and ordered to discontinue the psychotropic medications. Resident #3's representative was aware and safety precaution education was provided. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's medication administration record for September 2024 revealed they received antidepressant (Lexapro 10mg daily for depression from 9/5/2024 to 9/16/2024) and antipsychotic (Seroquel/Quetiapine Fumarate 50 mg daily at bedtime for psychosis from 9/4/2024 to 9/15/2024). There was no documented evidence in the progress notes regarding the verbal orders received by Registered Nurse #7 from the Psychiatric Nurse Practitioner #1. In addition, there was no physician's order noted regarding the verbal order for Resident #3 received. Review of a facility medication error/adverse reaction form dated 9/16/2024 documented Resident #3 had an error involving wrong resident and wrong medication. The error documented Lexapro 20 mg by mouth daily and Seroquel 50 mg by mouth daily at bedtime ordered in error for wrong resident. There was no documentation in the progress note from the Psychiatric Nurse Practitioner #1. 2) Resident #8 was admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Major Depression Disorder and other Sequalae of Cerebral Infarction. A Comprehensive Minimum Data Set, dated dated dated [DATE] documented Resident #8 had moderate cognitive impairment. The resident required a walker and a wheelchair for locomotion. The resident required supervision with eating, maximal assistance with toileting and bed mobility. Resident #8 was taking anti-psychotic and anti-depressant medications. Review of Psychiatric Nurse Practitioner #1's consult note dated 9/4/2024 recommended Resident #8's Seroquel(antipsychotic) to be changed from Seroquel 25 mg x2 daily to Seroquel 50 mg daily and a gradual dose reduction of Lexapro(antidepressant) from 20 mg to Lexapro10 mg daily due to no behaviors reported and confusion had improved. Review of Resident #8's medication administration record for September 2024 revealed their Lexapro 10 mg dose reduction recommendation from 9/4/2024, was not initiated until 9/19/2024. There was no documented evidence of Resident #8's Seroquel medication frequency being changed from 25mg x2daily to 50 mg daily. Review of Psychiatric Nurse Practitioner #1's consult note dated 9/11/2024 documented Resident #8 was taking Seroquel 50 mg two times daily, Neurontin 100 mg two times daily, Lexapro 10mg daily and Namenda 5 mg two times daily. The doses for the Lexapro and Seroquel were not accurately reflected. Resident #8's recommendation was a gradual dose reduction of Seroquel 25mg x2 daily to 50mg daily at bedtime due to no behaviors reported and confusion had improved. Resident #8's medication regimen was documented incorrectly on their psychiatry consult note dated 9/11/2024 as the resident had not received the recommended changes from the previous psychiatry consult on 9/4/2024. Review of Resident #8's medication administration record for September 2024 revealed their Seroquel dosing did not change as recommended from 9/4/2024. Resident #8 received Seroquel 25 mg x2 daily from 8/20/2024 until 9/11/2024 and Seroquel 25 mg daily at bedtime from 9/11/2024 until 9/18/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2025 at 1:35 PM, Registered Nurse #1 stated on 9/16/2024 they were reviewing the resident's discharge medications with their family representative and Resident #3's representative stated the resident does not take those medications. Registered Nurse #1 stated they went back and checked the medication list and called Psychiatric Nurse Practitioner #1(the prescriber) and they stated the medications were ordered in error. Registered Nurse #1 stated they discontinued the medications immediately, assessed Resident #3 and the Psychiatric Nurse Practitioner #1 followed up with Resident #3 and their representative after discharge. Registered Nurse #1 stated the Director of Nursing #2 was informed about the medication error and a house wide in-service was completed on medication errors and Registered Nurse #7, who transcribed the order received disciplinary action. During a telephone interview on 4/15/2025 at 2:16 PM, the Psychiatric Nurse Practitioner #1 stated the recommendation for the Lexapro and Seroquel were intended for Resident #8, but the medications were ordered for Resident #3. Resident #3 received the medications for 12 days. The Psychiatric Nurse Practitioner #1 stated the facility called them and informed them about the medication error as soon as it was discovered, and they discontinued the medication immediately for Resident #3. The Psychiatric Nurse Practitioner #1 stated their first interaction with Resident #3 was on 8/28/2024, and their last interaction was a home visit in the community on 9/18/2024. The Psychiatric Nurse Practitioner #1 stated they did not consult Resident #3 during their facility rounds on 9/4/2024. The Psychiatric Nurse Practitioner #1 stated Resident #8 also did not have any adverse effects from the recommended changes not being reflected in their medication profile. All recommended medication changes and additions were started as soon as the error was identified. The Psychiatric Nurse Practitioner #1 stated currently they write a brief synopsis of the visit and recommendation. The unit nurse and the nursing supervisor signs off on the consultation and then it goes to the Director of Nursing #1. This provides a triple check to avoid errors. The Psychiatric Nurse Practitioner #1 stated the changes in the process came about due to the medication error incident that was discovered on 9/16/2024. During a telephone on 4/15/2025 at 2:25 PM, Registered Nurse #7 stated they remember the medication error incident that was discovered on 9/16/2024. Registered Nurse #7 stated there was another resident that had the same last name as Resident #3 and they were taking a verbal order over the phone for new medications after the psychiatry consults were completed. Registered Nurse #7 stated they received the verbal orders from the Psychiatric Nurse Practitioner and hand wrote the orders on paper, then went into the electronic medical record and entered the orders, because there were a couple of other residents, they had to enter orders for. Registered Nurse #7 stated they wrote down the last name of the resident, but they did not realize there were two residents with the same name because they were not in the facility regularly. Registered Nurse #7 stated it was extremely busy that afternoon and they had admissions. Registered Nurse #7 stated they got written up for the incident and disciplined for the error, and this was the first time something like that happened to them. They were devastated. Registered Nurse #7 stated they transcribed these types of verbal orders on Wednesdays all the time and had not experienced any errors in the past until the incident. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 4/17/2025 at 9:13 AM, the Director of Nursing #2 stated on 9/16/2024, they recall there was a medication error discovered, related to 2 residents with similar names. The Director of Nursing #2 stated usually the list of residents provided by the Psychiatric Nurse Practitioner #1 identifies the residents by last name and first name. The Director of Nursing #2 stated on this occasion there was probably a verbal order provided for the nursing supervisor the Psychiatric Nurse Practitioner #1 and Registered Nurse #7 made an error and input the medication orders on the wrong resident. The Director of Nursing #2 stated they think when Registered Nurse #7 entered Resident #8's name into the electronic medical record system, Resident#3's name popped up and they entered the medication into Resident #3's medical chart in error. This was an honest mistake and an isolated incident. The Director of Nursing #2 stated they completed an audit of the charts for residents receiving psychotropic medications in the facility. The Director of Nursing #2 stated they cannot recall if they noted the discrepancies in Resident #8's medication orders when they conducted the chart audit. The Director of Nursing #2 stated if they had recognized a discrepancy in Resident #8's medication orders, they would have investigated the issue, but they could not recall the details of what occurred at that time. The Director of Nursing #2 stated this would have been a medication error if they had noticed any discrepancies in Resident #8's chart. 10 NYCRR 415.12(m)(2)