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	03/30/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification and abbreviated (2564447) surveys conducted 03/23/2026 - 03/30/2026, the facility did not ensure an appropriate discharge plan for one (1) of three (3) residents (Resident #30) reviewed for discharge. Specifically, Resident #30 was sent to the hospital for a medical condition and provided a discharge notice while hospitalized . The discharge was appealed, and the resident was not accepted back to the facility when medically cleared to return to the facility. Findings included:A facility policy titled Discharge reviewed 1/2026 documented it is the policy of facility that each resident has the right to remain in the facility and not transfer or discharge a resident unless a transfer or discharge from the facility is: the resident/family/representative request, necessary for the resident's welfare and the resident's needs cannot be met in the facility; the resident/patient requires immediate transfer or discharge based on the residents/patients urgent medical need; the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident, or the health of individuals in the facility would otherwise be endangered.Resident #30's diagnoses included vascular dementia, unspecified severity with other behavioral disturbance, other sequelae of cerebral infarction, constipation, and atrial fibrillation. The quarterly Minimum Data Set, dated [DATE] documented Resident #30 had short- and long-term memory problems, had verbal and physical behavior symptoms towards others and was dependent for toileting and transfers. A nursing progress note dated 06/20/2025 at 3:54 AM, documented Resident #30 vomited coffee ground emesis. The physician was notified, and Resident #30 was transferred to the hospital via ambulance. Physician order dated 06/20/2026 documented to transfer Resident #30 to the hospital emergency department to rule out gastrointestinal bleed. The discharge Minimum Data Set, dated [DATE], documented an unplanned discharge to a short-term general hospital with return anticipated. The Interdisciplinary Care Plan Meeting form, completed by the Director of Social Service on 06/24/2025, documented a meeting was held on 06/17/2025 and attended by the Assistant Administrator, Minimum Data Set Coordinator, Resident Coordinator, Assistant Director of Nursing, Dietitian, Social Worker, resident's companion, resident's two guardians as well as phone participation by two physicians and a physical therapist. There was no documented evidence discharge planning was discussed. The resident's care plan had no documented evidence of a planned discharge. The Transfer/Discharge Notice dated 06/30/2025 documented the interdisciplinary team determined Resident #30 would be discharged on 06/30/2025 (same day). The reasons for discharge were: the resident's needs could not be met after reasonable attempts at accommodation in the facility; the safety of individuals in the facility would be endangered; and the health of individuals in the facility would be endangered. The evidence for the reasons given were due to interference from the resident's two guardians. There was no documented evidence in the notice that Resident #30 endangered the health and safety of individuals. The notice documented the resident's right to appeal the discharge. Further review of Resident #30's electronic medical record revealed no documented evidence of the interdisciplinary team's plan for discharging the resident. There were no nursing progress notes after 06/20/2025; no social work progress notes after (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/13/2025; and no physician notes after 04/30/2025. There was no documented evidence as to the resident's needs that could not be met or evidence that the resident endangered the health and safety of individuals. There was no discharge summary. A review of the appeal hearing by the Administrative Law Judge dated 09/22/2025, documented the resident was medically cleared for discharge from the hospital on [DATE] and the facility refused to readmit Resident #30. The judge ruled the facility's discharge plan was not appropriate and the facility had to readmit the resident. During an interview on 03/26/2026 at 11:30 AM, the Administrator stated Resident #30's Guardians, Resident #30 and the New York State Department of Health were notified on discharge plan on 06/30/2025. A Notice of Discharge was sent to both Guardians via Registered Mail, and a hand-delivered notification was delivered to Resident #30 at the hospital. The Administrator stated Resident #30's needs could not be met after reasonable attempts at accommodation, the safety of individuals in the facility would be endangered and the health of individuals in the facility would be endangered. The behavior of the Guardians impacted the staff's ability to care for Resident #30 in addition to endangering the health and safety of staff in the facility were reason for discharge. They stated Resident #30's Guardians appealed the discharge decision, and the facility and family presented to a hearing on 09/22/2025. The Administrator stated the Judge from the New York State Department of Health required the facility to readmit the resident. 10 NYCRR 415.3(h)(4)(iii)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the recertification survey from 03/23/2026 to 03/30/2026, the facility did not ensure that a copy of the notice of transfer or discharge was sent to the State Long Term Care Ombudsman for one (1) of three (3) residents (Resident #30) reviewed for Hospitalization. Specifically, there was no documented evidence that a notice of transfer was sent to the New York State Ombudsman when Resident #30 was sent to the hospital on June 20, 2025. The findings included:Resident #30's diagnoses included vascular dementia with other behavioral disturbance, other sequelae of cerebral infarction, constipation, and atrial fibrillation.The quarterly Minimum Data Set, dated [DATE] documented Resident #30 had short- and long-term memory problems, had verbal and physical behavior symptoms towards others and was dependent for toileting and transfers. A nursing progress note dated 06/20/2026 at 3:59 AM documented Resident #30 was transferred to the hospital via ambulance.During an interview on 03/26/2026 at 9:24 AM the Director of Social Services stated Ombudsman notification of hospital and discharges were sent via email monthly. The Director of Social Services stated they were unable to locate Ombudsman notification for the June 20, 2025 hospitalization. During an interview on 03/26/2026 at 6:44 PM, the Assistant Administrator stated the Social Services Director and Medical Record Department were unable to locate an email notification to the ombudsman for the 6/20/2025 transfer to the hospital for Resident #30. They stated forms were usually emailed to the ombudsman office monthly was an oversight. 10 NYCRR 483.15 (C) (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey from 3/23/26 - 3/30/26, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically, during a Norovirus (very contagious stomach virus that causes nausea, vomiting and diarrhea) outbreak on 4/11/2025, the facility did not ensure an infection surveillance plan based on facility assessment was implemented for the identification, containment and prevention of infections and did not complete and submit a Nosocomial Outbreak Reporting Application ([NAME]) report as requested by the New York State Department of Health (NYSDOH) on 04/16/2025; and 2) the facility's infection control line list was incomplete and did not document signs and symptoms of infection, diagnostic tests/laboratory results, precautions used and outbreak potential.The findings included: The policy titled Routine Infection Control Surveillance last reviewed August 2025 documented assessment of all residents for any/all changes in symptoms or conditions that may be indictive of infection should be performed on an ongoing basis. 1) Facility Infection Control Tracking Sheets dated 04/11/2025 documented Gastroenteritis (stomach virus) for three (3) residents on [NAME] unit and one (1) resident on East unit with associated symptoms. An electronic mail dated 04/16/2025 sent to the facility Director of Nursing by the New York State Department of Health documented submission of a Nosocomial Outbreak Reporting Application report was required for a single case of a reportable pathogen identified in a resident of a nursing home or a cluster of cases above the baseline (in this situation, facility identified a cluster of gastrointestinal illness cases). During an interview and observation on 03/25/2026 at 11:17 AM, the Director of Nursing stated the facility had a few cases of Norovirus on 04/11/2025 and they were aware of an electronic mail from the New York State Department of Health requesting a Nosocomial Outbreak Reporting Application report be submitted after the outbreak was reported on 04/16/2025. The Director of Nursing stated the facility did not submit the requested Nosocomial Outbreak Reporting Application report to the New York State Department of Health and was unaware why the report was not submitted. They stated they were not the Director of Nursing during April 2025, and the previous Director of Nursing should have submitted the report. They stated the facility increased cleaning, provided symptom management, staff training/education on infection control, and residents affected were placed on contact precautions and remained in their rooms for duration of illness which lasted four (4) or five (5) days. They stated an infection control tracking sheet was completed for just one day only, 04/11/2025, and was not completed for other dates during the outbreak or updated with symptoms/management. The Director of Nursing stated they did not know why the surveillance tracking was not continued throughout the outbreak and it should have been. The Director of Nursing stated that the New York State Department of Health should have been contacted with the report of the outbreak immediately when it was discovered on 04/11/2025. They stated unit nursing staff were in-serviced on How to Prevent Norovirus/Outbreak strategies on 04/14/2025 and that the in-service education should have started immediately on 04/11/2025. There may have been verbal infection control/contact precaution training completed earlier but they were unaware. During an interview on 03/25/2026 at 11:38 AM, the Infection Preventionist Registered Nurse stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they worked at the facility three days a week as an Infection Preventionist for approximately the last 18 months, including the 04/11/2025 norovirus outbreak. They stated they did not complete the infection control tracking sheet dated 04/11/2025 and were unaware who completed it. They stated their role during outbreak was to collect data on the affected residents on the units, increase surveillance on the units and provide staff education immediately. They stated infection control in-service education for staff was conducted on 04/14/2025 and they may have had verbal training with unit staff but were unaware. The Infection Preventionist Registered Nurse stated surveillance tracking sheets should have been completed daily during outbreak and they were not sure why it was not done. 2) The Infection Control Line List for January, February and March 2026 documented residents on antibiotic therapy including wound infection, respiratory infection, urinary tract infection, bacteremia, and Clostridium Difficile. The list lacked documentation for infection signs and symptoms, diagnostic tests/ laboratory tests results, precaution and outbreak potential. During an interview on 03/30/2026 from 11:35 AM to 12:03PM, the Infection Control Preventionist stated they monitored and made rounds on residents with infections, monitored residents admitted with infections and on antibiotic therapy. They initiated and used the line list for surveillance, did diagnostic testing when a resident had symptoms, and were responsible for conducting staff education on infection control. During the interview, the Infection Control Preventionist reviewed the monthly antibiotic line list of January, February and March 2026 and confirmed the line list did not include signs and symptoms of infection, diagnostic tests ordered and results of the tests, and type of precautions used. During an interview on 03/30/2026 at 1:26 PM, Director of Nursing stated that Infection Control Preventionist was responsible for keeping track of infections and making sure surveillance included signs and symptoms, diagnostic tests with results and precautions to prevent outbreaks. The Director of Nursing stated they were working with Infection Control Preventionist on improving the surveillance list. 10 NYCRR 415.19(a) (1-3)