STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335455	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Richmond Healthcare and Rehab Center	88 Old Town Road Staten Island, NY 10304

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews conducted during an abbreviated survey (ID#2720832), the facility failed to ensure that a designated resident representative was notified of changes in the resident's condition. This was evident in one (1) out of four (4) residents sampled (Resident #1). Specifically, Resident #1 was assessed on 08/14/2025 to have developed moisture associated skin damage (caused by prolonged exposure to moisture from sources such as urine, stool, sweat or wound drainage) to sacrum and bilateral buttocks and treatment was ordered. Resident #1's designated representative was not notified of changes in Resident #1's skin condition. The findings are: The facility policy and procedure titled Notification of Resident's Change in Condition dated 04/2020 documented detection of a resident's change in condition can be reported to a licensed nurse by staff at any level, and to the resident's responsible party. The nurse is responsible for documenting in the medical record the date, time, and name, each time the Physician/Physician Extender, Resident or Responsible Party was notified (how they were notified such as telephone, face to face) actions taken, and resident's response to treatment. Resident #1 was admitted to the facility with diagnoses including Dementia, Anemia, End Stage Renal Disease on Hemodialysis (three (3) days a week), Diabetes Mellitus, Atrial Fibrillation, Coronary Artery Disease, Heart Failure, Chronic Obstructive Pulmonary Disease, Malnutrition, and Respiratory Failure. The admission Minimum Data Set (a resident assessment tool) dated 01/09/2025, documented Resident #1 had moderately impaired cognition. A review of the Electronic Medical Record revealed that on 08/12/2025 at 10:11 AM Registered Nurse #3 requested a wound care consultation. Further review of the Electronic Medical Record revealed no documentation by Registered Nurse #3 of an identified wound. There is also no documentation of the attending physician being notified of a wound. There is no evidence that a wound assessment was conducted until 08/14/2025 when Registered Nurse #2 performed a wound assessment. An altered skin notes by Wound Care Nurse, Registered Nurse #2 dated 08/14/2025, documented Resident #1 was assessed with moisture associated dermatitis at the sacrum and bilateral buttocks. It appeared moist, pink/red, no odor, no drainage and no pain. Treatment was ordered. A review of the Treatment Administration Record dated from 08/14/2025 - 08/31/2025 Hydrophilic Cream (Triad) 0/1 Paste Topical, every shift. Apply Triad Cream mixed with A&D Ointment to the sacrum and bilateral buttocks every shift and when soiled after cleaning with soap and water times 30 days. There was no documented evidence that Resident #1's designated representative was notified of the moisture associated skin damage. On 01/23/2026 at 10:00 AM, Resident #1's designated representative was interviewed and stated they were not aware Resident #1 had developed moisture associated skin damage to their sacrum and bilateral buttocks in the facility. On 02/04/2026 at 4:27 PM, Registered Nurse #3 (Unit Manager) was interviewed and stated they did not notify Resident #1's designated representative because the wound care nurse, Registered Nurse # 2, is responsible for notifying family members of skin problems. Registered Nurse #3 stated that the wound care nurse, Registered Nurse #2 assessed Resident #1 and received the treatment order. Registered Nurse #3 stated they were the unit manager on the unit, but they were not very involved with wounds since the facility has a wound care nurse that comes into the facility daily to follow up (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the wounds. On 02/05/2026 at 12:01 PM, Wound Care Nurse, Registered Nurse # 2, was interviewed and stated they usually notify the family when a resident has a skin issue, but they missed notifying Resident #1's representative. Wound Care Nurse, Registered Nurse #2 stated that the nurses on the unit can also notify family members and could have notified Resident #1's representative of the moisture associated with skin damage. On 02/04/2026 at 6:13 PM, the Director of Nursing stated was interviewed and stated they have a full-time wound nurse responsible for notifying the family when a resident develops any skin changes. The Director of Nursing stated the wound nurse should have notified Resident #1's designated representative when Resident #1 developed the moisture associated skin damage to sacrum and bilateral buttocks. The Director of Nursing stated if there is a concern happening on the weekends or holidays, it is the unit nurse's responsibility to notify the family of any change in skin condition. 10 New York Code, Rules, and Regulations 415.3(e)(2)(ii)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Abbreviated Survey (ID #2720832) the facility failed to ensure the Minimum Data Set assessments accurately reflect each resident's status. This was evident in one (1) out of four (4) residents (Resident #1) sampled. Specifically, 1) Resident 1 was admitted to the facility from the hospital on [DATE] and was identified with Cellulitis (a common, potentially serious bacterial skin infection). The Minimum Data Set, dated [DATE] assessment did not reflect Resident #1's skin condition. 2) the hospital discharged , and Patient Review Instrument dated 12/30/2025, revealed Resident #1 was discharged to the facility with eight wounds to various body areas. A facility admission note dated 01/02/2026 documented Resident #1 had wounds to sacrum, bilateral buttocks, bilateral hips, and gangrene to all toes and bilateral heels. The Minimum Data Set assessment dated [DATE] did not reflect Resident #1's wounds. The findings are: The facility policy titled Minimum Data Set Completion Policy dated 10/2020 documented the purpose to identify each resident's needs problems and strengths to establish a course of action through an individualized comprehensive care plan and to assure accurate and timely completion of the Minimum Data Set 3.0 and to fulfill Federal regulations. Resident #1 was initially admitted to facility with diagnoses including Atrial Fibrillation, Anemia, Coronary Artery Disease, Heart Failure, Respiratory Failure, Chronic Obstructive Pulmonary disease, Malnutrition, End Stage Renal disease (on dialysis three days a week), and Muscle weakness. The Minimum Data Set (a resident assessment tool) dated 07/25/2025 documented Resident #1 had moderately impaired cognition. Resident #1 is dependent on toileting hygiene and is always continent of bladder/bowel and requires substantial/maximal assistance for bed mobility (helper does more than half the effort.) The assessment identified Resident #1 with no skin problem or pressure ulcer present. A review of the hospital discharge record and Patient Review Instrument dated 07/15/2025 documented primary diagnosis Bacteremia (the presence of bacteria in the bloodstream) with Cellulitis. The lower right extremity has full thickness skin loss (a wound that goes through the entire skin layers and into the fat subcutaneous tissue) measuring 8.0-centimeter x 6.0-centimeter x 0.2-centimeter, wound bed 20 percent fibrinous tissue (stringy, gel-like consistency may appear white or yellowish), peri-wound intact. The Patient Review Instrument also documented Resident #1 has statis ulcer and wound care required. A review of a Nursing admission Assessment by Registered Nurse #4 dated 07/21/2025 documented antibiotic for skin infection (did not identify area of skin). Resident #1 was referred to Medical Doctor and wound care for bilateral lower legs. A medical admission notes by Medical Doctor #2 dated 07/22/2025 at 10:15 AM identified Resident #1 with diabetic foot ulcer and cellulitis. A review of a hospital Discharge Medical Record dated 12/30/2025 revealed Resident #1 was discharged to the facility with several wounds to various body areas: Stage III ulcer to sacrum measured 4.0-centimeter x 5.0-centimeter x 0.2. Left hip deep tissue injury measured 5.0-centimeter x 4.0 centimeter.Right hip is unstageable. Dry scab came off measured 1.0-centimeter x 0.8.Left heel deep tissue injury measured 6.0-centimeter x 4.0-centimeterRight heel deep tissue injury measured 5.0-centimeter x 5.0-centimeterLeft toes dry gangrene, cold to touch.Right great toe black necrosis, dry stable. Cold to touch and all toes gangrene.Left bunion towards left dorsum has partial thickness skin loss. A review of a nursing Admission/readmission note by Registered Nurse #5 dated 01/02/2026 at 6:45 PM documented pressure wound to sacrum, wounds to bilateral hips, gangrene to all toes and bilateral heels. A Physician History and Physical note by Medical Doctor #2 dated 01/02/2026 at 7:10 PM documented Resident #1 with moisture associated with skin damage (refers to skin inflammation or erosion caused by prolonged exposure to moisture from sources such as urine, stool, sweat or wound drainage). A Wound/Skin Assessment note written by Registered Nurse #2 (wound care nurse) dated 01/05/2026 at 12:18 PM, documented that they assessed Resident#1 with a right hip superficial abrasion, moisture associated dermatitis to sacrum with partial thickness erosion, bilateral lower (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremities unremarkable, bilateral heels without redness, bruising, open areas or signs and symptoms of breakdown. Bilateral feet are unremarkable. This assessment did not correlate with the hospital discharge assessment. A review of a Surgical Note by Wound Care Specialist, Physician Assistant #1 dated 01/07/2026 documented a detailed skin examination of Resident #1's buttocks, sacrum, coccyx, left ischium, right ischium, left trochanter, and right trochanter. The sacrum wound was identified moisture associated skin damage and the left hip identified as Kennedy terminal ulcer phenomenon (a type of skin sore that typically develops in patients during the final stages of life). The Minimum Data Set (a resident assessment tool) dated 01/09/2025, documented Resident #1 had moderately impaired cognition. The skin condition section only documented Moisture Associated Skin Damage. There was no documented evidence that assessment was done of the unstageable ulcer to the right hip, gangrene toes and wound to left bunion - full thickness skin loss. During an interview on 02/04/2026 at 9:43 AM, Minimum Data Set Coordinator #1 stated they are responsible for the completion of the Minimum Data Set assessment dated [DATE]. Minimum Data Set Coordinator #1 stated they reviewed the hospital discharge record for Resident #1 and were aware of the multiple wounds treated in the hospital. Minimum Data Set Coordinator #1 stated they called the Wound Nurse - Registered Nurse #1 and asked if they had evaluated Resident #1 and Wound Nurse - Registered Nurse #1 told them they and Medical Doctor #1 examined Resident #1 and that the assessments are accurate. Minimum Data Set Coordinator #1 stated they noticed the multiple wounds were not reflected in Registered Nurse #2's assessment but did not question them. Minimum Data Set Coordinator #1 stated they validated the accuracy of their assessment when they asked Registered Nurse #1 if the skin assessment was done. Minimum Data Set Coordinator #1 stated they trusted Registered Nurse #2 and based their assessments on them. Minimum Data Set Coordinator #1 also stated each assessor is responsible for the accuracy of assessment. Minimum Data Set Coordinator #1 stated they do not physically assess or visually check residents' skin as the facility has a wound nurse to perform skin assessments. During an interview on 02/04/2026 at 9:18 AM, the Minimum Data Set Director stated they are responsible for entering Resident #1's diagnoses and coordinating with nursing and medical doctors. The Minimum Data Set Director stated the Minimum Data Set coordinators are responsible for reading the hospital records when residents are admitted to the facility and to look for the medications and diagnoses. The Minimum Data Set Director stated they read the hospital records and maybe they overlooked the ulcers that were in the hospital records. The Minimum Data Set Director stated that the Minimum Data Set completion is based on the assessment documented in the medical record. 10 New York Code, Rules, and Regulations 415.11(b)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during survey, the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice to maintain their highest practicable physical wellbeing. This was evident for one (1) out of four (4) residents (Resident #1) sampled. Specifically, Resident #1 was admitted to the facility with intact skin to the sacrum (a triangular, shield-shaped bone at the base of the spine) and buttocks and subsequently developed moisture associated skin damage (erosion of the skin caused by prolonged exposure to urine, stool, sweat, or wound drainage.) Treatment was not initiated until [DATE] without documented evidence of the effectiveness of treatment between [DATE] and [DATE]. Resident #1 was transferred to the hospital on [DATE] with increased leukocytosis (increased white blood cells indicating infection) and was readmitted to the facility on [DATE] with eight (8) new wounds, four (4) of which lacked a nursing assessment or physician's order for further treatment. This deficient practice resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are: A facility policy titled Nursing admission Assessment with a revision date of 08/2014 indicated that it is the policy that all residents are assessed on admission and care plans are developed based on the assessments. The purpose is to ensure that all residents' needs are identified and met. The Registered Nurse completes the nursing admission assessment by reviewing all questions with the resident/family member to obtain past medical history/hospitalization and current concerns and risk factors. Addresses all care plans for potential concerns (falls, pressure ulcers). Document all other pertinent information in the integrated progress notes. A undated facility policy titled Wound Management, Pressure Injury/Ulcer Care and Prevention indicated that the purpose of the policy is to ensure that evidence based best practices, national guidance are followed and standardized to minimize the potential of inconsistencies that may lead to infections, prevent pressure injury formation whenever possible by effectively treating existing pressure injuries, recognizing those residents at risk for pressure injury, and effectively implementing individualized treatment plans utilizing the most effective pressure injury prevention and management strategies. Resident #1 was admitted to the facility with diagnoses including end stage renal disease (permanent kidney failure) on hemodialysis (three days a week), diabetes mellitus (refers to a group of diseases that affect how the body uses blood sugar), and protein calorie malnutrition (a severe nutritional deficiency caused by inadequate intake of calories, protein, or both). The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #1 had moderately impaired cognition. Resident #1 was dependent on toileting hygiene and is always continent of bladder/bowel and requires substantial/maximal assistance for bed mobility (helper does more than half the effort.) The assessment identified Resident #1 with no skin problem or pressure ulcer present. A review of the admission assessment, revealed Registered Nurse #1 performed a skin assessment of Resident #1's sacrum and bilateral buttocks and documented no wounds or redness were present. A review of the Braden Scale Pressure Injury Risk dated [DATE] revealed that Wound Care Registered Nurse #2 assessed Resident #1 to be at moderate risk for developing pressure injury as indicated by a score of 14. A review of the electronic medical record revealed that on [DATE] at 10:11 AM, Registered Nurse #3 requested a wound care consultation for Resident #1. Further review of the electronic medical record revealed no documentation by Registered Nurse #3 of an identified wound. There is also no documented evidence of the attending physician being notified of a wound. There is no documented evidence that a wound assessment was conducted until [DATE] when Wound Care Registered Nurse #2 performed a wound assessment. A review of the wound assessment dated [DATE] at 12:22 PM, revealed Resident #1 was assessed by Wound Care Registered Nurse #2 and was identified with moisture associated dermatitis (common skin inflammation causing itchy, dry rashes or irritated skin) on the sacrum and bilateral buttocks, appeared moist, pink/red, no odor, no drainage and no pain. A Physician's Order written by Medical (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Doctor #1 dated [DATE] documented Hydrophilic Cream (designed to absorb moisture, soothe skin, or manage wound exudate, often acting as a protective barrier) apply paste topically every shift. Apply Triad cream mixed with A&D Ointment to sacrum and bilateral buttocks every shift and when soiled after cleansing with soap and water for 30 days. Diagnosis: Irritant contact dermatitis (a nonallergic skin reaction occurs when an irritant damages the skin outer protective layer) due to fecal, urinary or dual incontinence. A nursing note dated [DATE] by Registered Nurse #4 documented skin opening to bilateral buttocks. Wound Nurse notified and Medical Doctor to evaluate. A Medical Note written by Nurse Practitioner #1 dated [DATE] at 10:53 AM, revealed Resident #1 was seen and examined for the moisture associated skin damage to bilateral buttocks. There were no new orders documented for Resident #1. A review of the treatment record that is dated [DATE] through [DATE], revealed the last treatment was applied on [DATE] at 6:00 AM. The next documented assessment of wound progression is dated [DATE] by Nurse Practitioner #1 who noted that Resident #1 was observed with moisture associated skin damage to the sacrum.A Physician's Order dated [DATE] by Nurse Practitioner #1 documented Hydrophilic Cream to be applied to the sacrum after cleansing with soap and water. A wound consultation was ordered on [DATE]. On [DATE] the order for the treatment was discontinued and new treatments ordered and administered until Resident #1 was transferred from dialysis to the emergency room on [DATE] for increased leukocytosis. Review of a surgical note written by Wound Care Specialist Physician Assistant #1 dated [DATE], revealed an examination of Resident #1's buttocks, sacrum, coccyx (tailbone), left ischium and right ischium (lower posterior back) was done. The sacrum has moisture associated skin damage with moderate serosanguinous exudate (drainage mixed with blood and yellow fluid). Measurements identified as length 6.0 centimeters, width 5.0 centimeters, depth 0.1 centimeters, and wound area 30.00 centimeters. It was documented that the wound was stable, and to continue with topical wound dressing therapy. A Physician's Order dated [DATE] documented Honey (Medi-Honey) 80%, apply Gel, topically, during the day shift, after cleansing sacral moisture associated skin damage with normal saline. Apply Medi-honey followed by calcium alginate then cover with silicone bordered dressing daily and as needed. There is no documented evidence that the current treatment was evaluated for effectiveness.Record review revealed Resident #1 was transferred to the hospital on [DATE] from dialysis due to increased leukocytosis.A review of a hospital Nursing Inpatient Note dated [DATE] at 1:08 AM documented Braden Scale score 13 indicating moderate risk for development of pressure ulcers/injuries. Mobility very limited, friction and shear- problem. Localized abnormality: Moisture Associated Skin Damage (MASD) location: sacrum. Stage 1: Trochanter left- no edema. Stage II: Trochanter right- no edema- wound drainage-none. Second stage II: Sacrum/coccyx 6-centimeter x 4 centimeters, no edema, wound drainage none. Deep Tissue Injury: right and left heel, no edema, wound edema none. Wound-other than pressure ulcer/injury (includes open surgical wounds/incisions): Left bunion, no edema, no drainage. Discoloration bilateral toes. Resident #1 was uncooperative and combative to measure the wound properly. The hospital discharge assessment dated [DATE] identified Resident #1 with unstageable wound to the right hip, deep tissue injury to left hip, deep tissue injury to left/right heel, dry gangrene of the left toe, right great toe as black and necrotic, all toes gangrene, left bunion with partial thickness (damage extending through the epidermis and potentially into the dermis) and skin loss. A review of a hospital Discharge Medical Record dated [DATE], revealed Resident #1 was discharged to the facility on [DATE] with several wounds to various body areas including but not limited to Stage III ulcer to sacrum measured 4.0-centimeter by 5.0-centimeter by 0.2 centimeters. A review of a nursing Admission/readmission note by Registered Nurse #5 dated [DATE] at 6:45 PM documented pressure wound to sacrum, wounds to bilateral hips, gangrene to all toes and bilateral heels. A Physician's History and Physical note by Medical Doctor #2 dated [DATE] at 7:10 PM documented Resident #1 with moisture associated skin damage to sacrum. The note did not identify the Stage III ulcer to the sacrum or the other wounds documented on the hospital discharge summary. A Physician's Order dated [DATE] by Medical Doctor #3 documented (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Collagenase Clostridium (an enzyme that breaks done collagen, acts as a debriding agent for wounds) 250 unit/gram, apply ointment topically daily. Cover with clean dressing and secure with tape, transparent film dressing, Kling (medical bandage), bordered gauze daily for diagnosis of dermal ulcer (an open, crater-like sore on the skin caused by the loss of the epidermis and top layers of the dermis, often due to pressure, poor circulation, or infection). The order did not identify a specific body site for the treatment to be applied.A review of the Treatment Administration Record dated from [DATE] through [DATE], revealed treatment was applied on [DATE] and [DATE] as indicated by letter G (Given). The order was discontinued on [DATE]. A review of the Impaired Skin Integrity care plan dated [DATE] assessed Resident #1 with impaired skin integrity and presence of skin breakdown as evidenced by moisture associated skin damage to sacrum. The care plan did not identify the presence of left hip deep tissue injury, right hip unstageable, left/right heel deep tissue injuries, left toes dry gangrene, right toe black/necrotic, all toes gangrene, and left bunion partial thickness skin loss. A Wound/Skin Assessment note written by Wound Care Registered Nurse #2 dated [DATE] at 12:18 PM, documented that they assessed Resident #1 with a right hip superficial abrasion, moisture associated dermatitis to sacrum with partial thickness erosion, bilateral lower extremities unremarkable, bilateral heels without redness, bruising, open areas or signs and symptoms of breakdown. Bilateral feet are unremarkable. This assessment did not correlate with the hospital discharge assessment. A Physician's Order dated [DATE] documented Honey (Medi honey) 80 percent, apply gel topically. Apply Medi honey followed by calcium alginate and over with silicone bordered gauze daily and as needed. Diagnosis: Irritant contact dermatitis due to fecal, urinary or dual incontinence. A Physician's Order dated [DATE] documented Hydrophilic cream (Triad). Apply paste topically after cleansing left hip abrasion with normal saline. Apply triad cream and cover with silicone bordered gauze daily and as needed for Diagnosis: Other skin changes. A review of the Treatment Administration Record dated [DATE] through [DATE], revealed that the physician's order for Hydrophilic cream (Triad) was applied as ordered. The treatment was changed on [DATE] to Honey (Medi honey) 80 percent followed by calcium alginate to apply topically daily to left hip after cleansing with normal saline. There was no documented evidence of treatment for four (4) wounds: right hip, left bunion full thickness skin loss, bilateral gangrene toes. A review of a facility Surgical Note by Wound Care Specialist Physician Assistant #1 dated [DATE] documented a detailed skin examination of Resident #1's buttocks, sacrum, coccyx, left ischium, right ischium, left trochanter and right trochanter (thigh bone). The sacrum wound was identified as moisture associated skin damage and the left hip identified as Kennedy terminal ulcer phenomenon (a type of skin sore that typically develops in patients during the final stages of life). There was no documented evidence that an assessment was done of the unstageable ulcer to the right hip, gangrene toes and wound to left bunion - partial thickness skin loss. During an interview on [DATE] at 11:26 AM, Nurse Practitioner #1 stated they assessed Resident #1 on [DATE] with redness and no skin break to the sacrum and bilateral buttocks. Nurse Practitioner #1 stated they did not follow up with the moisture associated with skin damage to sacrum and bilateral buttocks because the unit nurse would notify them if the wound was healed or if they needed additional treatment. Nurse Practitioner #1 stated they do not recall Resident #1 having gangrenous feet and toes during the times they examined Resident #1. Nurse Practitioner #1 stated they frequently examined Resident #1 because of sporadic refusal of care, treatment, and treatment with dialysis. Nurse Practitioner #1 stated Resident #1's refusal of care/treatment could have contributed to the moisture associated skin damage. During an interview on [DATE] at 4:27 PM, Registered Nurse #3 stated they worked on Resident #1's unit from [DATE] through [DATE]. Registered Nurse #3 stated they were notified that Resident #1 was observed with a skin problem to their sacrum (unsure of details) on [DATE]. Registered Nurse #3 stated they wrote an order for wound consultation on [DATE] after they assessed Resident #1. Registered Nurse #3 stated they do not see any documentation of their assessment or that they notified the medical doctor to obtain treatment. Registered Nurse #3 stated Resident #1 was assessed by Wound Care Registered Nurse #2 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	on [DATE] and local treatment was ordered on [DATE]. Registered Nurse #3 stated that the unit nurses were responsible for providing treatment and notifying Wound Care Registered Nurse #2 if the moisture associated skin damage/bilateral buttocks deteriorated, but not if the wounds were improving. Registered Nurse #3 stated Wound Care Registered Nurse #2 was responsible for monitoring/documenting the effectiveness of treatment. Registered Nurse #3 stated Wound Care Registered Nurse #2 should have known the last day of treatment and documented wound healing. During an interview on [DATE] at 5:33 PM, Registered Nurse #5 stated they readmitted Resident #1 on [DATE] at 6:45 PM. Registered Nurse #5 stated Resident #1 was assessed with pressure injury to the sacrum and open wounds to bilateral hips. Registered Nurse #5 stated Resident #1's legs were wrapped from below the knees down to the feet. Registered Nurse #5 stated they unwrapped the dressing from the lower extremities and observed that the bilateral heels and all the toes were necrotic. Registered Nurse #5 stated they did not notify Medical Doctor #2 or Nursing Supervisor #1 who were on duty that Resident #1 had multiple wounds, but they notified the incoming night shift nurse (unsure of name). Registered Nurse #5 stated they did not initiate a care plan for the wounds because Wound Care Registered Nurse #2 would reassess the wounds. Registered Nurse #5 stated they should have notified Medical Doctor #2 and obtained wound care treatment orders on [DATE]. During an interview on [DATE] at 2:04 PM, Wound Care Registered Nurse #2 stated they assessed Resident #1 upon initial admission to the facility and there was no pressure injury observed. Wound Care Registered Nurse #2 stated Resident #1 developed the moisture associated skin damage to sacrum and bilateral buttocks on [DATE]. They stated they were not aware treatment was not ordered on [DATE] and that the unit nurse should have notified the doctor and obtained treatment orders. Wound Care Registered Nurse #2 stated that the unit nurses should not have waited for them to assess Resident #1 because they (wound care nurse) were covering the units and making weekly wound rounds, they cannot cover everything. Wound Care Registered Nurse #2 stated that the nurse on the unit could have documented progress of the wound and effectiveness of treatment in Resident #1's progress notes. Wound Care Registered Nurse #2 stated that the nurses conducted skin assessments on Resident #1's shower days and could have notified them when the treatment was completed. Wound Care Registered Nurse #2 stated they do not know why the treatment was ended on [DATE] and no one notified them if the wounds were healed. Wound Care Registered Nurse #2 stated they reviewed Resident #1's readmission ([DATE]) discharged documents from the hospital but did not review the hospital skin assessment, they wanted to assess Resident #1's skin with their own eyes; they do not read other people's assessments. Wound Care Registered Nurse #2 stated Resident #1 did not develop pressure ulcers in the facility. During an interview on [DATE] at 3:30 PM, Registered Nurse #6 stated they were the unit manager on Resident #1's unit when Resident #1 was readmitted on [DATE]. Registered Nurse #6 stated they reviewed the hospital medical record (unsure of date) and saw the documentation of the wounds but did not notify the wound care nurse. Registered Nurse #6 stated they do not get involved with skin assessment because Wound Care Registered Nurse # 2, is responsible for skin assessment. Registered Nurse #6 stated they are aware of the discrepancies with the wounds identified in the hospital records and the wounds documented in Resident #1's medical record. During an interview on [DATE] at 3:53 PM, Hospital Doctor #1 stated Resident #1 was admitted to their hospital on [DATE] and was discharged on [DATE] to the facility. Hospital Doctor #1 stated Resident #1 had previously eight (8) documented wounds ([DATE]) and they found a new one when Resident #1 was readmitted to the hospital on [DATE]. The additional wound was on the right middle finger in the proximal interphalangeal joint (joints between the bones of the fingers), and the bone was exposed. Hospital Doctor #1 stated Resident #1 had multiple risk factors for the development of pressure ulcers including being bedbound and malnourished. Hospital Doctor #1 stated they did not know if the wounds were avoidable or unavoidable given Resident #1's comorbidities. Hospital Doctor #1 stated Resident #1 expired on [DATE] with a presumed infection due to infection of wounds and ischemic, necrotic tissues in their legs and feet. During a follow up (continued on next page)

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	335455	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmel Richmond Healthcare and Rehab Center	88 Old Town Road Staten Island, NY 10304

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	interview on [DATE] at 1:00 PM, Hospital Doctor #1 stated Resident #1 was admitted to the hospital with multiple pressure ulcers as evidenced by the wound care team note dated [DATE] (Hospital Doctor #1 was reading the assessment from hospital wound nurse documentation) documenting Resident #1 had sacral stage III, left hip deep tissue injury (refers to damage that occurs beneath the skin's surface), left heel deep tissue injury, right heel deep tissue injury, right hip unstageable, left toes gangrene, right great toe black necrosis and left bunion (bony bump that forms on the joint at the base of the big toe). During an interview on [DATE] at 2:17 PM, Medical Doctor #2 stated they readmitted Resident #1 on [DATE] in the evening (unsure of time). Medical Doctor #2 stated they reviewed Resident #1's hospital discharge medical record (unsure of date) and observed the moisture associated with skin dermatitis but did not observe the wounds to Resident #1's bilateral hips. Medical Doctor #2 stated they attempted to assess Resident #1's lower extremities but Resident #1 refused. Medical Doctor #2 stated Resident #1 has the right to refuse to be examined. Medical Doctor #2 stated the procedure for the facility when a resident refuses, is to endorse to the incoming doctor but they do not recall endorsing to another doctor. Medical Doctor #2 stated that they did not order a podiatry consult because they did not assess Resident #1's lower extremities that were wrapped in bandages. There was no documentation evidence that Medical Doctor #2 documented Resident #1 refused to be examined on [DATE]. During an interview on [DATE] at 1:10 PM, Wound Care Specialist Physician Assistant #1 stated they visit the facility every Wednesday for weekly wound rounds. Wound Care Specialist Physician Assistant #1 stated they do not assess the whole body of a resident because Wound Care Registered Nurse #2 tells them what part of the body to assess. Wound Care Specialist Physician Assistant #1 stated they initially assessed Resident #1 on [DATE] with moisture associated skin damage to sacrum. Wound Care Specialist Physician Assistant #1 stated they and Wound Care Registered Nurse #2 examined Resident #1 on [DATE] when they were readmitted back to facility ([DATE]). Wound Care Specialist Physician Assistant #1 stated Resident #1 had moisture associated skin damage to sacrum and a left hip Kennedy terminal ulcer. Wound Care Specialist Physician Assistant #1 stated the left hip was observed to be necrotic. Wound Care Specialist Physician Assistant #1 stated they did not see the wound on Resident #1's right hip and they were not aware of the wounds on Resident #1's left bunion and gangrenous toes.During an interview on [DATE] at 6:13 PM, the Director of Nursing stated they observed there was an order for wound consultation on [DATE], but there is no documented evidence Registered Nurse #3 assessed the wound area, notified the medical doctor and obtained treatment for skin changes. The Director of Nursing stated Registered Nurse #3 should have notified the Medical Doctor and obtained treatment order. The Director of Nursing stated Registered Nurse #3 should not have waited for Wound Care Registered Nurse #2 to evaluate the skin changes unless the wound nurse was on the unit. The Director of Nursing stated the wound care nurse should have reviewed the hospital discharge documentation and compare if Resident #1 was admitted with all the wounds identified in the hospital records. The Director of Nursing stated Registered Nurse #5 (readmitted Resident #1 on [DATE]) should have notified Medical Doctor #2 of the wounds identified since Resident #1 refused assessment from Medical Doctor #2. During an interview on [DATE] at 7:40 PM, the Administrator stated they think the root cause analysis of their case with Resident #1 was that Wound Care Registered Nurse #2 did not review the hospital records which led to discrepancy of documentation and possibly delaying of treatment and that is why the wound care nurse is no longer with them. The Administrator stated the podiatry consultation is not warranted because Resident #1 was being seen by Wound Care Specialist Physician Assistant #1 and that includes assessing Resident #1's skin. The Administrator stated they were not aware Resident #1's lower extremities were not examined by Wound Care Specialist Physician Assistant #1 because the wound care nurse did not address the wounds on Resident #1's lower extremities. 10 New York Codes, Rules, and Regulations 415.12

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F 0710 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during a survey, the facility failed to ensure that medical care for each resident was effectively supervised by a physician. This was evident for one (1) out of four (4) residents (Resident #1) sampled. Specifically, 1) Resident #1 developed Moisture Associated Skin Damage (erosion of the skin caused by prolonged exposure to urine, stool, sweat, or wound drainage) to the sacrum (a triangular, shield-shaped bone at the base of the spine) and bilateral buttocks on 08/12/2025 and treatment was ordered on 08/14/2025 to be completed for 30 days. A Surgical Note by Physician Assistant #1 dated 12/17/2025 indicated wound deterioration. There was no documented evidence of effectiveness of treatment between 08/14/2025 and 09/14/2025.2) Resident #1 was readmitted to the facility on [DATE] with eight (8) wounds to various body areas, four (4) of which lacked nursing and physician assessment from 01/02/2026 through 01/10/2026. Additionally, there was no documented evidence of a physician's order for treatment of four (4) of the wounds. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings are:The facility's policy titled Physician Services /MD Communication Log with a revised date 09/2025 states that the facility's purpose is to ensure medical care of each resident is supervised by a physician, and that another physician supervises the medical care of the resident when their attending physician is unavailable. Supervising the medical care of residents means participating in the residents' medical status and providing consultation or treatment when called by the facility. Physicians are assigned to specific nursing units to provide consistent coverage for the resident's medical needs. Physician visits after the initial admission visit may alternate between personal visits by a physician assistant, nurse practitioner or clinical specialist.Resident #1 was admitted to the facility with diagnoses including end stage renal disease (permanent kidney failure) on hemodialysis (three days a week), diabetes mellitus (refers to a group of diseases that affect how the body uses blood sugar), and protein calorie malnutrition (a severe nutritional deficiency).The Minimum Data Set (a resident assessment tool) dated 07/25/2025 documented Resident #1 had moderately impaired cognition. Resident #1 is dependent on toileting hygiene and is always continent of bladder/bowel and requires substantial/maximal assistance for bed mobility (helper does more than half the effort.) The assessment identified Resident #1 with no skin problem or pressure ulcer present. A review of the Braden Scale Pressure Injury Risk dated 07/24/2025 revealed that Registered Nurse #2 (Wound Care Nurse) assessed Resident #1 to be at moderate risk for developing pressure injury as indicated by a score of 14. According to the document a total score of 18 would indicate the resident was at risk for developing pressure injuries. A review of the electronic medical record revealed that on 08/12/2025 at 10:11 AM, Registered Nurse #3 requested a wound care consultation. Further review of the electronic medical record revealed no documentation by Registered Nurse #3 of an identified wound. There is also no documentation of the attending physician being notified of a wound. There is no documented evidence that a wound assessment was conducted until 08/14/2025 when Registered Nurse #2 performed a wound assessment. A review of the wound assessment by Registered Nurse #2 dated 08/14/2025 at 12:22 PM, revealed Resident #1 was assessed by Registered Nurse #2 and was identified with moisture associated dermatitis (common skin inflammation causing itchy, dry rashes or irritated skin) in sacrum (a triangular, shield-shaped bone at the base of the spine) and bilateral buttocks, appeared moist, pink/red, no odor, no drainage and no pain. A Physician's Order written by Medical Doctor #1 dated 08/14/2025 documented Hydrophilic Cream (designed to absorb moisture, soothe skin, or manage wound exudate, often acting as a protective barrier) apply paste topically every shift. Apply Triad cream mixed with A&D Ointment to sacrum and bilateral buttocks every shift and when soiled after cleansing with soap and water x 30 days. Diagnosis: Irritant contact dermatitis due to fecal, urinary or dual incontinence. A nursing note dated 08/15/2025 by Registered Nurse #4 documented skin opening to bilateral buttocks. Wound Nurse notified and Medical Doctor to evaluate. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Medical Note written by Nurse Practitioner #1 dated 08/16/2025 at 10:53 AM, revealed Resident #1 was seen and examined for the moisture associated skin damage to bilateral buttocks. A review of the treatment record from 08/14/20225 through 09/14/2025, revealed the last treatment was applied on 09/14/2025 at 6:00 AM. Following the treatment session on 09/14/2026, there is documented evidence of wound progression or a clinical until 11/29/2025 when Nurse Practitioner #1 documented that Resident #1 was observed with moisture associated skin damage to sacrum.A Physician's Order dated 11/29/2025 by Nurse Practitioner #1 documented Triad Cream to be applied to the sacrum after cleansing with soap and water. A wound consultation was also ordered on 11/29/2025. On 12/01/2025 the order for treatment was discontinued and new treatments were ordered and administered until Resident #1 was transferred from dialysis to the emergency room on [DATE] for increased leukocytosis. A review of a facility Surgical Note written by Wound Care Specialist Physician Assistant #1 dated 12/17/2025, revealed there was an examination of Resident #1's buttocks, sacrum, coccyx (tailbone), (left ischium and right ischium (lower posterior back). The sacrum has moisture associated skin damage with moderate serosanguinous exudate (drainage mixed with blood and yellow fluid). Measurements identified as length 6.0 centimeters, width 5.0 centimeters, depth 0.1 centimeters, and wound area 30.00 centimeters. It was documented that the wound was stable, and to continue with topical wound dressing therapy. A Physician's Order dated 12/18/2025 documented Honey (Medi-Honey) 80%, apply gel, topically, during the day shift, after cleansing sacral moisture associated skin damage with normal saline. Apply Medi-honey followed by calcium alginate then cover with silicone bordered dressing daily and as needed. There is no documented evidence indicating if the treatment was effective or if the wounds were healed. Record review revealed Resident #1 was transferred to the hospital on [DATE] from dialysis due to increased leukocytosis (high white blood cell count).A review of a hospital Discharge Medical Record dated 12/30/2025, revealed Resident #1 was discharged to the facility on [DATE] with several wounds to various body areas including but not limited to a Stage III ulcer to sacrum measured 4.0-centimeter by 5.0-centimeter by 0.2 centimeters. The hospital discharge assessment dated [DATE] identified Resident #1 with unstageable wound to the right hip, deep tissue injury to left hip, deep tissue injury to left/right heel, dry gangrene of the left toe, right great toe as black and necrotic, all toes gangrene, left bunion with partial thickness (damage extending through the epidermis and potentially into the dermis) skin loss. A review of a nursing Admission/readmission note by Registered Nurse #5 dated 01/02/2026 at 6:45 PM documented pressure wound to sacrum, wounds to bilateral hips, gangrene to all toes and bilateral heels. A Physician's History and Physical note by Medical Doctor #2 dated 01/02/2026 at 7:10 PM documented Resident #1 with moisture associated skin damage to sacrum. The note did not identify the Stage III ulcer to the sacrum or the other seven (7) wounds documented on the hospital discharge summary. A Physician's Order dated 01/02/2026 by Medical Doctor #3 documented Collagenase Clostridium (a debriding agent used to remove necrotic tissue) 250 unit/gram, apply topically daily. Cover with clean dressing and secure with tape, transparent film dressing, Kling (medical bandage), bordered gauze daily for diagnosis of dermal ulcer (an open, crater-like sore on the skin caused by the loss of the epidermis and top layers of the dermis). The order did not identify a specific body site for the treatment to be applied.A review of the Treatment Administration Record dated from 01/02/2026 through 01/10/2026, revealed treatment ordered on 01/02/2026 was applied on 01/03/2026 and 01/04/2026 as indicated by letter G (Given). However, the area where the treatment was applied was not identified. A Wound/Skin Assessment note written by Registered Nurse #2 (wound care nurse) dated 01/05/2026 at 12:18 PM, documented that they assessed Resident#1 with a right hip superficial abrasion, moisture associated dermatitis to sacrum with partial thickness erosion, bilateral lower extremities unremarkable, bilateral heels without redness, bruising, open areas or signs and symptoms of breakdown. Bilateral feet are unremarkable. This assessment did not correlate with the hospital discharge assessment. A Physician's Order dated 01/05/2026 documented Honey (Medi honey) 80 percent, apply gel topically. (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Apply Medi honey followed by calcium alginate and over with silicone bordered gauze daily and as needed. Diagnosis: Irritant contact dermatitis due to fecal, urinary or dual incontinence. A Physician's Order dated 01/05/2026 documented Hydrophilic cream (Triad). Apply paste topically after cleansing left hip abrasion with normal saline. Apply Triad cream and cover with silicone bordered gauze daily and as needed for Diagnosis: Other skin changes. There was no documented evidence for treatment of four (4) wounds: right hip, left bunion partial thickness skin loss, bilateral gangrene toes. There was no documented evidence a podiatry consultation was ordered. A review of a facility Surgical Note by Wound Care Specialist Physician Assistant #1 dated 01/07/2026 documented a detailed skin examination of Resident #1's buttocks, sacrum, coccyx, left ischium, right ischium, left trochanter and right trochanter (thigh bone). The sacrum wound was identified as moisture associated skin damage and the left hip identified as Kennedy terminal ulcer phenomenon (a type of skin sore that typically develops in patients during the final stages of life). There was no documented evidence for an assessment of the gangrene toes and wound to left bunion - partial thickness skin loss was completed. There was no documented evidence of treatment to the right hip, gangrene toes, and left bunion partial thickness wound. During an interview on 01/27/2026 at 2:17 PM, Medical Doctor #2 stated they readmitted Resident #1 on 01/02/2026 during the evening (unsure of time). Medical Doctor #2 stated they reviewed Resident #1's hospital discharge medical record (unsure of date) and observed the moisture associated skin dermatitis but did not observe the wounds to Resident #1's bilateral hips. Medical Doctor #2 stated they attempted to assess Resident #1's lower extremities but Resident #1 refused. Medical Doctor #2 stated Resident #1 has the right to refuse to be examined. Medical Doctor #2 stated the procedure for the facility when a resident refuses, is to endorse to the incoming doctor but they do not recall endorsing to another doctor. Medical Doctor #2 stated that they did not order a podiatry consult because they did not assess Resident #1's lower extremities that were wrapped in bandages. There was no documentation evidence that Medical Doctor #2 documented Resident #1 refused to be examined on 01/02/2026. During an interview on 02/04/2026 at 1:10 PM, Wound Care Specialist Physician Assistant #1 stated they conduct weekly wounds rounds at the facility on Wednesdays. Wound Care Specialist Physician Assistant #1 stated they did not assess Resident #1's entire body because Registered Nurse #2 (wound care nurse), tells them what part of Resident #1's body to assess. Wound Care Specialist Physician Assistant #1 stated they initially assessed Resident #1 on 12/17/2025 with moisture associated skin damage to sacrum. Wound Care Specialist Physician Assistant #1 stated they and Registered Nurse #2 examined Resident #1 on 01/07/2026 when they were readmitted back to facility (01/02/2026) and Resident #1 was assessed with moisture associated skin damage to sacrum and a left hip Kennedy terminal ulcer. Wound Care Specialist Physician Assistant #1 stated the left hip was observed to be necrotic. Wound Care Specialist, Physician Assistant #1 stated they did not see the wound on Resident #1's right hip and they were not aware of the wounds on Resident #1's lower extremities. During an interview on 02/18/2026 at 2:42 PM, Medical Doctor #3 stated they were the attending physician on Resident #1's unit from October 2025 through 01/10/2026. Medical Doctor #3 stated they never saw Resident #1 when they were readmitted to the unit on 01/02/2026. Medical Doctor #3 stated Resident #1 was readmitted to the facility on [DATE] by Medical Doctor #2 and that they believed the appropriate treatment was ordered. Medical Doctor #3 stated Resident #1 was examined by the wound care team (Registered Nurse #2 and Physician Assistant #1) and that if Resident #1 arrived with multiple wounds, they believed everything was put in place. Medical Doctor #3 stated they were not aware Resident #1 refused to have their extremities examined by Medical Doctor #2 during their readmission. Medical Doctor #3 stated that the unit nurses should have communicated with them. Medical Doctor #3 stated they were not aware Resident #1 was readmitted with gangrenous toes and multiple wounds. Medical Doctor #3 stated they did not order podiatry consultation because they did not examine Resident #1. During an interview on 01/26/2026 at 2:45 PM, the Medical Director stated they were aware of the readmission of Resident #1 to the facility. The Medical Director stated they (continued on next page)

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F 0710 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	reviewed Resident #1's hospital discharge notes and saw the list of wounds documented. The Medical Director stated Medical Doctor #2 should have ordered treatments for all the wounds. The Medical Director stated they reviewed Resident #1's diagnoses and medications on 01/02/2026 but did not physically examine Resident #1. The Medical Director stated they are responsible for overseeing the medical doctors and if Resident #1 refused to be examined, Medical Doctor #2 should have endorsed the refusal to the incoming doctor. 10 New York Codes, Rules, and Regulations 415.15(b)(1)(i)(ii)