STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335476	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Friendly Home	3156 East Avenue Rochester, NY 14618

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interviews and record review conducted during the Recertification Survey from 12/11/2025 to 12/19/2025, it was determined that for one (Resident #61) of five residents reviewed, the facility did not ensure that PRN (as needed) orders for anti-psychotic drugs (medications used to treat symptoms of psychosis) were limited to 14 days. Specifically, there were several instances in which Resident #61 had as needed (PRN) Haldol (an antipsychotic medication) orders that exceeded the 14 day timeframe. Additionally, over several months, Pharmacist #1 identified through monthly Medication Regimen Reviews the Haldol orders and recommended they be reordered every 14 days. This is evidenced by the following: Resident #61 had diagnoses including dementia, depression, and anxiety. The Minimum Data Set (a resident assessment tool) dated 10/13/2025 revealed Resident #61 was severely impaired cognitively, was on hospice (specialized medical care for people nearing end of life), and received antipsychotic medications. The current Comprehensive Care Plan revealed Resident #61 was nearing end of life, was enrolled in hospice on 05/06/2024 and received antipsychotic medications with interventions including administering medications as ordered. Review of Resident #61's physician orders from 05/01/2025 to 12/19/2025 revealed the following:- Haloperidol Lactate (Haldol) give 0.25 milliliters (0.5 milligrams) by mouth two times a day as needed (PRN) for behaviors, ordered 05/15/2025 (discontinued 09/19/2025).- Haloperidol Lactate (Haldol) give 0.5 milliliters (1 milligram) by mouth every eight (8) hours as needed for agitation/aggression not responsive to nonpharmacological measures, ordered 10/07/2025 (discontinued 11/25/2025). - Haloperidol Lactate (Haldol) give 0.5 milliliters (1 milligram) by mouth every eight (8) hours as needed for agitation/aggression not responsive to nonpharmacological measures for 14 days, ordered 11/25/2025 (current order). Review of the Consultant Pharmacist Medication Regimen Reviews completed by Pharmacist #1 for the previous 11 months included the following:a. On 05/24/2025 Pharmacist #1 noted that Resident #61 had a PRN (as needed) order for Haloperidol 0.5 milligrams two times a day as needed since 05/15/2025. Pharmacist #1 recommended to evaluate the resident, document and reorder every 14 days to continue the need for PRN (as needed) anti-psychotic use. The section used by the medical team to address the recommendation included documentation dated 06/03/2025 by Nurse Practitioner #2 that they agreed (with the recommendation), the resident was on hospice, they would add a note, and it was part of the resident's palliative program. Signatures were also noted on the signature lines for the Director of Nursing (Director of Health Services) and Medical Director.b. On 07/24/2025 Pharmacist #1 noted Resident #61 had a PRN (as needed) order for Haloperidol 0.5 milligrams two times a day as needed since 05/15/2025. Pharmacist #1 recommended to evaluate the resident, document and reorder every 14 days to continue the need for PRN (as needed) anti-psychotic use. The section used by the medical team to address the recommendation included documentation by Nurse Practitioner #2 (date illegible) that they disagreed with the recommendation due to the resident being on hospice and it was for their comfort. Signatures were also noted on the signature lines for the Director of Nursing (Director of Health Services) and Medical Director.c. On 10/24/2025 Pharmacist #1 noted Resident #61 had a PRN (as needed) order for Haloperidol one (1) milligram every eight (8) hours as needed since 10/07/2025. Pharmacist #1 (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommended to evaluate the resident, document and reorder every 14 days to continue the need for PRN (as needed) anti-psychotic use. The section used by the medical team to address the recommendation included documentation by Nurse Practitioner #2 dated 11/04/2025 that they disagreed with the recommendation, as the resident was on hospice, the medication was occasionally being used, and they would document the need for three (3) months for quality of life. A signature was noted on the line for the Director of Nursing (Director of Health Services) dated 11/19/2025.d. On 11/24/2025 Pharmacist #1 noted Resident #61 had a PRN (as needed) order for Haloperidol one (1) milligram every eight (8) hours as needed since 10/07/2025. Pharmacist #1 recommended to evaluate the resident, document and reorder every 14 days to continue the need for PRN (as needed) anti-psychotic use. During a telephone interview on 12/19/2025 at 11:42 AM, Pharmacist #1 said they reviewed residents' medications in the electronic medical record monthly and they would look for (but not limited to) duplicate medication orders, that gradual dose reductions were done properly and that PRN (as needed) medications were not used for long periods of time. Pharmacist #1 stated they would generate a report of identified irregularities, which was sent to the facility and the medical prescriber. If the medical prescriber disagreed with a recommendation, they would have to explain why. Pharmacist #1 said the reports were then sent to the Medical Director and were stored in a binder. Pharmacist #1 stated antipsychotic medications had to have documentation on why it was needed and how the resident was benefiting from it, and had to be reordered every 14 days. Pharmacist #1 stated they had provided recommendations in May, July, October and November 2025 with regards to Resident #61's ordered PRN Haldol, and the medical prescriber's response was the resident was on hospice. Pharmacist #1 said there was no exceptions to the regulation with regards to the medication having to be ordered every 14 days. During an interview on 12/19/2025 at 11:04 AM, Nurse Practitioner #2 said they went through the monthly medication regimen reviews done by the pharmacist, they would decide if they agreed or disagreed with the recommendation, write it down on the paper, which would then go to the Director of Nursing (Director of Health Services) and the Medical Director. Nurse Practitioner #2 stated no one had ever come to them with concerns about their decisions (related to medication regimen reviews) after they were turned in. Nurse Practitioner #2 said Haldol was an example of an antipsychotic medication, and it was usually used for residents on hospice for delirium (change in mental abilities) and nausea. Nurse Practitioner #2 stated as needed (PRN) antipsychotic medications had to be reordered every 14 days per the regulation, and either the physician or the mid-level provider (nurse practitioner or physician assistant) would have to enter a new order. Nurse Practitioner #2 said Resident #61 was on hospice and had a current PRN order for Haldol, which was placed on 11/25/2025 and was beyond the 14 days. They did not have an explanation for why the Haldol order was active over the 14 days. Nurse Practitioner #2 confirmed their signature on the Consultant Pharmacist Medication Regimen Reviews for Resident #61 dated 05/24/2025 and 07/24/2025 and stated they thought there was an exception to the regulation for residents on hospice. During an interview on 12/19/2025 at 2:29 PM, the Director of Health Services said when the monthly medication regimen reviews were delivered, they are put in the nurse practitioner's mailbox, who would say what they are doing (agree or disagree). The reviews would then go to the Director of Health Services, who would make sure someone looked at them, and they would either send them back (to the medical provider) if they are blank, or sign them. The reviews would then go to the Medical Director. 10 NYCRR 415.12(l)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a recertification survey from 12/11/2025 to 12/19/2025, for two (2) (Resident #33 and #140) of three (3) residents reviewed for respiratory care, and two (2) (Resident #6 and #88) of five (5) residents reviewed for drugs and medications, the facility did not provide services to meet professional standards of quality. Specifically, Resident #6 had physician's orders for blood pressure to be obtained prior to receiving blood pressure medication, and the facility could not provide documentation the blood pressure was consistently obtained prior to the administration of the medication per the medical order. Resident #33 and Resident #140 had reportable instances of high blood glucose, and the facility could not provide documentation a medical provider was notified per the medical order. Resident #88 had physician's orders for measuring blood glucose levels and obtaining blood pressure and pulse before administering blood pressure medication, and the facility could not provide documentation that the medical provider was notified of blood glucose levels outside parameters as ordered, or that pulses were obtained prior to giving the medication. This is evidenced by, but not limited to: The facility policy Medication Administration, Documentation, and Premedication, dated August 2024 documented licensed nurses should verify physician's orders, check for hold parameters and laboratory values, perform vital signs for medications with parameters, and should document the results prior to administering the medication. 1. Resident #88 had diagnoses including diabetes, dementia, and high blood pressure. The Minimum Data Set (a resident assessment tool) dated 09/30/2025 revealed the resident had severely impaired cognition. Review of Resident #88's current physician orders revealed an order dated 03/25/2025 to measure the blood glucose level before each meal, notify a medical provider via a communication log for blood glucose less than 80 or greater than 300, and to notify a provider via phone call if the blood glucose was less than 70 or greater than 400. In addition, an order dated 10/01/2024 for metoprolol (a medication for high blood pressure) 25 milligrams daily with parameters to hold the metoprolol for a systolic blood pressure less than 100 and a heart rate (HR) less than 60. Review of Resident #88's electronic medical record (including but not limited to Medication Administration Records, Treatment Administration Records, blood glucose monitoring records, progress notes, and provider communication logs) from 09/01/2025 to 12/15/2025, revealed 11 instances of a blood glucose reading less than 80, eight (8) instances of a blood glucose reading less than 70, three (3) instances of a blood glucose reading greater than 300, and two (2) instances in which there was no documentation the resident's blood glucose was checked. The facility could not provide documentation the medical provider was informed via the facility communication log or via phone call. Additionally, there was no documented heart rate for 103 out of 106 administrations of metoprolol. In an observation and interview on 12/18/2025 at 12:00 PM, Licensed Practical Nurse #3 demonstrated checking Resident #88's orders for metoprolol and acknowledged the hold parameters for the medication. Licensed Practical Nurse #3 demonstrated documenting in the Medication Administration Record and stated there was no area to document a pulse (heart rate) with the medication. Licensed Practical Nurse #3 said they checked Resident #88's pulse (heart rate) prior to administration but there was no area to document it. Additionally, Licensed Practical Nurse #3 said if they needed to notify a provider, they would contact the nursing supervisor or nurse manager, write a progress note, and include it in the 24-hour report. In an interview on 12/19/2025 at 11:00 AM, Licensed Practical Nurse #1 stated if a resident had a low blood glucose reading it would be documented in the provider notification log, and if the blood glucose was very low, they would notify the nursing supervisor or nurse manager who would then notify the provider. Licensed Practical Nurse #1 said if a resident had a low blood glucose reading, they would give them juice, and glucose tablets were not utilized at the facility. In an interview on 12/19/2025 at 11:57 AM, Registered Nurse Manager #1 stated if a blood glucose reading was outside of the parameters included in a resident's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order, it should be documented in the provider notification log, or the provider should have been called. Registered Nurse Manager #1 said there was no way to confirm the medical provider was made aware of the incident if the communication was not documented. Registered Nurse Manager #1 stated if a medication order had a hold parameter such as a pulse (heart rate), the vital signs should be documented in the Medical Administration Record. In an interview on 12/19/2025 at 03:19 PM, the Director of Health Services stated the licensed practical nurses do not directly notify the medical providers; if they needed to notify a medical provider, they would inform the nurse manager or the supervisor, who would utilize the on-call system to notify a provider. They said that nursing staff document provider notifications in a progress note, 2. Resident #33 had diagnoses including diabetes, pneumonia and heart failure. The Minimum Data Set, dated [DATE], revealed the resident had intact cognition. Review of current physician orders revealed an order dated 11/25/2025 for finger stick blood sugar testing before meals and at bedtime and the medical provider to be notified via written documentation for blood sugars less than 80 or greater than 250. Review of Resident #33's November and December 2025 Treatment Administration Records, and written documentation for notification from 11/26/2025 to 12/18/2025 revealed Resident #33 had 11 blood sugar results over 250 and the facility could not provide documentation the medical provider was informed nine (9) of the 11 reportable instances as ordered. Review of progress notes dated 11/26/2025 through 12/19/2025 revealed no documented evidence that a medical provider was made aware of blood sugar levels over 250 as ordered for the nine (9) reported instances. During an interview on 12/19/2025 at 12:19 PM, Licensed Practical Nurse Clinical Coordinator #1 stated blood sugars greater than 250 should be documented in the record book kept on the unit to notify medical providers. During an interview on 12/19/2025 at 12:27 PM, Registered Nurse Manager #4 stated nursing staff should follow the orders for blood sugar testing and reportable values should be documented and the medical provider should be informed. During an interview on 12/19/2025 at 1:44 PM, the Director of Health Services stated nurses should follow the orders for testing blood sugars and blood sugar parameters. The Director of Health Services said reportable blood sugar values should be documented and the medical provider should be informed. 3. Resident #6 had diagnoses including vascular dementia with anxiety, major depressive disorder, and hypertension (high blood pressure). The Minimum Data Set, dated [DATE], documented the resident had severely impaired cognition. Review of Resident #6 physician's orders revealed an order dated 06/27/2025 for lisinopril 10 milligrams (a medication for high blood pressure) to be given in the morning and hold the medication for systolic blood pressure (the first number in a blood pressure reading) less than 110. Review of Resident #6's electronic medical record (including but not limited to Medication Administration Records, Treatment Administration Records, Weights and Vitals Summary, and progress notes) from 10/01/2025 to 12/19/2025 revealed no documentation blood pressures were obtained prior to administering lisinopril for 66 out of 77 instances. In addition, for one (1) instance in which the medication was held due to outside parameters, there was no documentation of the resident's blood pressure. In an observation and interview on 12/19/2025 at 10:17 AM, Licensed Practical Nurse #3 stated Resident #6's blood pressure was checked before lisinopril was administered for 12/19/2025. Licensed Practical Nurse #3 said the blood pressure could be documented in a progress note but had not written one for Resident #6 because the lisinopril was not held for blood pressure parameters. In an observation and interview on 12/19/2025 at 10:34 AM, Registered Nurse Manager # 1 stated they expected nurses to obtain a blood pressure when there is a blood pressure parameter order for a medication. Registered Nurse Manager #1 said they could not verify Resident #6's blood pressure was obtained and documented daily per the physician's order. Registered Nurse Manager #1 stated nurses should document a blood pressure in the electronic medical record vital signs (Vitals Summary) or a progress note. In an interview on 12/19/2025 at 12:06 PM, the Director of Health Services stated they expected blood pressures to be obtained when there are parameters in a medication order. Director of Health Services #1 said nurses should document the blood pressure in the electronic medical record in vital signs (Vitals Summary) or in a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress note. In an interview on 12/19/2025 at 12:47 PM, Nurse Practitioner #1 said they expected to see vital signs documented and nurses should document the blood pressure in the vital signs (Vitals Summary). Upon review of Resident #6's electronic medical record, Nurse Practitioner #1 could not verify a blood pressure was obtained before the lisinopril was administered on 12/19/2025 and there were no vital signs documented for Resident #6 after 11/30/2025. 10 NYCRR 415.11(c)(3)(i)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during recertification and complaint (#2619460) surveys from 12/11/2025 to 12/19/2025, for three (3) (Resident's #85, #125, and #126) of ten (10) residents reviewed, the facility did not ensure the resident's environment remained as free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents. Specifically, Resident #85 was observed over several days to have unopened wine bottles unsecured at their bedside, Resident #85 was not care planned for personal alcohol possession or consumption and there were other residents with wandering tendencies residing on that unit. In addition, Resident #125 had a right-sided transfer bar attached to their bed and a gap of approximately four (4) inches was observed between the transfer bar and mattress, concerning of a potential area of entrapment (where an individual can be caught between components of a bed). The facility could not provide documented evidence that transfer bar and bed safety checks were performed every shift by Nursing staff. Lastly, Resident #126 was known to have wandering and exit seeking behaviors, and eloped (resident leaves the premises or safe area without the facility's knowledge and supervision) from the facility. Prior to Resident #126's elopement, the door was known to not be functioning properly, and the facility was unable to provide documentation that interventions were put in place to keep the resident safe on the unit. This is evidenced by the following:The facility policy Wander Monitor System Alarm, with an unknown date documented the reception desk monitors the main entrance for departures by residents with a wander guard bracelet. The facility policy Missing Member/Elopement dated September 2024, documented alarms do not replace necessary supervision and require maintenance and testing to ensure proper functioning. The Nurse Manager assigns a staff member to observe the resident at times when wandering behavior intensifies and initiates more frequent checks as needed. The facility policy Alcohol in Life Enrichment Programs with an unknown date, included consumption shall be monitored at programs where alcohol was served, the staff were to use a standard measurement of 1 (one) ounce of alcohol per drink, and a maximum drink limit of two (2) per resident. Additionally, the policy included for staff to serve alcohol to residents in designated areas only. The facility policy Transfer Bar with an unknown date, included a transfer bar being defined as a one-piece device attached to the bed frame on one of both sides of the bed that is grasped to aid in bed entry and exit, and bed mobility. The policy included that all staff were responsible to monitor residents with transfer bars to ensure they are in good working order and do not pose an immediate risk of entrapment or injury. Additionally, daily checks of the transfer bar were to be completed to ensure it is placed appropriately and does not pose a risk for entrapment. 1.Resident #126 had diagnoses including dementia, major depressive disorder and muscle weakness. The Minimum Data Set (a resident assessment tool) dated 10/16/2025 revealed the resident had moderate impaired cognitive function and had history of delusions and wandering. The Comprehensive Care Plan initiated on 01/07/2025 documented Resident #126 wore a wander guard bracelet (wearable device for elopement prevention) and had exit seeking behaviors, and interventions included to distract the resident from wandering by offering pleasant diversions. In several progress notes, License Practical Nurse #10 documented the following:- On 08/06/2025, Resident #126 was exit seeking and trying to put the code in for the [NAME] Unit door to open, was stating that they wanted to leave and was trying to get other residents to help them get through the door. - On 08/22/2025, Resident #126 was exit seeking and was stating staff were keeping them at the facility against their will. - On 08/23/2025 and 09/11/2025, Resident #126 was going into other resident's rooms and was exit seeking. In a progress note dated 09/15/2025 at 3:29 PM, Licensed Practical Nurse #7 documented Resident #126 was pacing the hallways and interrupted them several times while trying to complete the medication pass. In a progress dated 09/15/2025 at 6:07 PM, Licensed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse #11 documented Resident #126 was not on the unit, they initiated the appropriate policy in response, and Resident #126 returned to the unit around 6:30 PM. Review of the facility's investigation documented Concierge #1 reported hearing the alarm on the main door activate around 5:57 PM. They thought a resident at a party (occurring in the front room) had triggered the alarm, so they deactivated the alarm using a device at the front desk, and Resident #126 walked out of the building. The resident was returned to the facility by the police at 6:40 PM. Review of facility Maintenance Work Orders dated 08/15/2025, 08/21,2025, 09/03/2025, 09/04/2025, 9/14/2025, and 09/15/2025 revealed maintenance requests were made by five (5) different staff documenting the [NAME] unit door was not latching properly and was not secured. The work orders were signed by five (5) different maintenance staff as completed their portion. On 09/03/2025, Maintenance Technician #1 documented the vendor had been contacted. The facility was unable to provide documentation regarding response from the vendor for that date. During an interview on 12/18/2025 at 5:26 PM, Concierge #1 stated that on the evening of 09/15/2025, there was a party in a nearby room to the front door, and sometimes during parties the alarm would sound, and the door would not open due to a resident with a wander guard bracelet being nearby. Concierge #1 said they could just tap a button at the desk to let people in and out of the front door. Concierge #1 stated that on 09/15/2025, they did not know which residents were at a risk of wandering or elopement and had never seen Resident #126 before. When Resident #126 was at the door, they thought that they were a visitor, and they tapped the button at the desk to let them out. Concierge #1 knew that the [NAME] door had not been working as they and other staff had been putting work orders in to have the door looked at and fixed. During an interview on 12/19/2025 at 09:40 AM, Registered Nurse Manager #5 stated prior to Resident #126's elopement, they did not know that there had been a problem with the [NAME] Unit door. After Resident #126 got out of the building, they had staff sit at the door until a part arrived for the door to be fixed. Registered Nurse Manager #5 stated that if they had known the [NAME] Unit door was not functioning properly prior to the elopement, they should have done something more, at least 15-minute checks on the residents. During an interview on 12/19/2025 at 10:42 AM, The Director of Health Services stated that they were aware of the [NAME] Unit door issues in August, Maintenance could not re-create the problem, and they could not figure out what was wrong with the door. The Director of Health Services stated that Resident #126 would put their hat and coat on and would go to the door. When talking with them, one may not know that Resident #126 was a memory care resident. The Director of Health Services stated that the communication piece should have been better and that the team should have met and come up with a plan. 2. Resident #85 had diagnoses that included dementia, reduced mobility, and subdural hemorrhage (internal bleeding inside the skull). The Minimum Data Set, dated [DATE], documented that the resident was mildly cognitively impaired. Review of Resident #85's Comprehensive Care Plan and Kardex (a care plan used by Certified Nursing Assistants for daily care) as of 12/15/2025 did not include that the resident was safe to have alcoholic beverages at their bedside. Review of Resident #85's medical orders did not include self-administration or personal possession of alcoholic beverages. During observations on 12/11/2025 at 11:01AM and 12/12/2025 at 10:07 AM, a four (4)-pack of serving-sized wine bottles were observed unopened and sitting on Resident #85's nightstand. During an observation on 12/15/2025 at 01:51 PM, two (2) serving-sized wine bottles were observed unopened and sitting on Resident #85's nightstand. During an interview on 12/18/2025 at 01:06 PM, Certified Nursing Assistant #5 stated they were aware that Resident #85 had wine in their bedroom. During an interview on 12/18/2025 at 01:28 PM, Licensed Practical Nurse #5 stated they were unaware of residents being permitted to keep alcohol in their rooms and that if they were to find alcohol in a resident's room, they would confiscate it and inform the nurse manager. During an interview on 12/18/2025 at 04:27 PM, Licensed Practical Nurse Clinical Coordinator #3 stated that they were aware that Resident #85 had alcohol in their room and that there were residents with wandering tendencies on the unit. During an interview on 12/19/2025 at 10:04 AM, Registered Nurse (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manager #3 stated it was a safety risk for residents to have alcohol kept unsecured in their rooms due to possible medication interactions or a resident accessing the alcohol who was not supposed to have it. During an interview on 12/19/2025 at 12:29 PM, Nurse Practitioner #1 stated it was important to know if a resident drank alcoholic beverage regularly because of medications and adverse effects, changes in medical condition that may be secondary to alcohol use, and if they were sharing it with other residents. They said that residents have a right to alcohol use but should have provider approval. During an interview on 12/19/2025 at 01:25 PM, Medical Director #1 stated that most medications do not have significant interactions with alcohol, and it would not be pertinent for medical providers to know whether residents were drinking alcohol. They said that there would be a safety concern if a resident wandered into a room and consumed alcohol. During an interview on 12/19/2025 at 03:19 PM, the Director of Health Services stated that the facility policy for recreational alcohol included staff measuring alcoholic beverages and moderating resident consumption of alcohol, and it did not include personal alcohol possession. They said that the safety risks of a resident having personal possession of alcohol without staff awareness included medication interactions with alcohol and other residents with wandering tendencies consuming the alcohol. During an interview on 12/19/2025 at 12:42 PM, the Administrator stated they were not aware of residents having alcohol in their room. However, unless contraindicated or a reason that they may not have it, as long as the resident were alert and oriented, they would be allowed to have alcohol in their room. The Administrator stated that it would be monitored by the team and the nursing staff, but they did not know how it would be monitored, and that the resident would not need to be care planned for it. 3. Resident #125 had diagnoses including muscle weakness, osteoporosis, and a thoracic wedge compression fracture (break in a vertebra [a spine bone]). The Minimum Data Set, dated [DATE] revealed Resident #125 had moderately impaired cognition and was independent with bed mobility and ambulation. Review of the Comprehensive Care Plan revealed Resident #125 was independent with using a right transfer bar for bed mobility (as of 06/19/2025), and was at risk for entrapment related to the use of a transfer bar with interventions that included checking the transfer bar daily and ensure bed, transfer bar, wall, and mattress compatibility to prevent entrapment zones and monitor at regular intervals (revised 12/16/2025). In a progress note dated 06/10/2025 at 2:08 PM, Physical Therapist #1 documented recommending a right transfer bar for decreased pain during bed mobility. In a Bed Rail Assessment form dated 06/19/2025, Registered Nurse Manager #3 documented a right side rail placement recommendation and that the side rails/assist bar were indicated and would serve as an enabler to promote independence. Review of Maintenance Work Order #141804 dated 06/27/2025 included a right transfer bar on the bed was needed in Resident #125's room, and the work was completed at 10:13 AM on 06/27/2025. Review of December 2025 Task documentation (certified nursing assistants' documentation) revealed no documented bed safety checks of the transfer bar until 12/16/2025. During an observation on 12/11/2025 at 9:11 AM, Resident #125 was observed dressed in day clothes, sleeping in bed. At 10:19 AM, Resident #125 was not observed in their bed or room, and a gap of approximately three (3) inches was observed between the metal transfer bar and the mattress on the bed frame. At 2:25 PM, a gap of approximately more than four (4) inches was observed from the mattress to the transfer bar. Additionally, the mattress was noted to not be fitted into the bed frame. Registered Nurse Manager #3 was in the room and observed the gap between the transfer bar and mattress. During an observation on 12/12/2025 at 9:36 AM, Resident #125 was observed with a different bed frame and a plastic transfer bar. During an interview on 12/15/2025 at 10:42 AM, Director of Building Services #1 stated they took the bed (observed on 12/11/2025) out of Resident #125's room and put in a new bed. During an interview on 12/15/2025 at 2:31 PM, Registered Nurse Manager #3 stated the process for a resident to get a transfer bar would include a request from the resident or a recommendation from Therapy, followed by a transfer bar evaluation which was done by a registered nurse. Consent would be obtained from the family and then the transfer bar would be put on by Maintenance. Registered Nurse Manager #3 stated they believed quarterly assessments (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were done through Maintenance to check for entrapment risks, and if a staff member noticed something (with the bed or transfer bar), they should tell someone. Registered Nurse Manager #3 stated Resident #125 had the transfer bar for some time after experiencing a compression fracture, they were independent and did everything themselves, and had been getting weaker so they opted to keep the transfer bar on the bed. Registered Nurse Manager #3 stated they had seen Resident #125 get out of bed (with the previous bed, transfer bar and mattress) and they never saw the mattress move. Registered Nurse Manager #3 stated they ordered Resident #125 a new bed (current bed) because the mattress was moving on the previous one and it had different corners (mattress corner holders), but when there was weight in the bed, the mattress did not move. During an interview on 12/19/2025 at 11:59 AM, Director of Building Services #1 stated a work ticket is entered if a transfer bar was needed in a certain room, on a certain side, and once Maintenance staff completed the work order (places the transfer bar) the ticket is closed. Maintenance staff would obtain a list generated by nursing from the front desk, which included all residents that had a transfer bar. A scheduled ticket would be generated for a quarterly check, and a maintenance technician would go through the list and perform the tests on each transfer bar and bed. Director of Building Services #1 stated when doing the quarterly assessments in August 2025, Resident #125 was not on the list of having a transfer bar (a check was not done), and they did not know why. During an interview on 12/19/2025 at 12:43 PM, Certified Nursing Assistant #7 stated they would know if a resident had a transfer bar because it would be on their Kardex (certified nursing assistants care plans), and they would see them on the resident's bed. Certified Nursing Assistant #7 stated they do safety checks to make sure they are positioned correctly and that the resident can use them, and they document the checks in the Kardex (electronic medical record). During an interview on 12/19/2025 at 2:29 PM, the Director of Health Services stated an evaluation is done by a registered nurse for residents with a transfer bar, the bars would be listed on the resident's care plan and there is a task for the certified nursing assistants to document every shift. Additionally, a tracker (list) of all residents with transfer bars was kept. The Director of Health Services stated at the beginning of the week, they noticed Resident #125 was not on the list and did not have the certified nursing assistant task set up (for transfer bar safety checks to be documented). The Director of Health Services stated somehow the resident got missed (from the list). 10NYCRR: 415.12(h)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, for one (1) of one (1) resident reviewed (Resident #138), the facility failed to ensure the resident was treated with respect and dignity and cared for in a manner and environment that promotes the maintenance or enhancement of the resident's quality of life. Specifically, staff entered the resident's room without knocking or announcing their presence, failed to communicate with the resident during care interactions, and moved the resident's personal items without discussing the action with the resident.The findings include:The facility policy Resident Rights/Facility Responsibilities revised 05/30/2024 included, but was not limited to, the facility will treat each resident with respect and dignity, recognize each resident's individuality, and protect and promote the rights of the resident, including the right to participate in his or her treatment. Resident #138 had diagnoses that included Parkinson's disease, right femur fracture, and dysarthria (a motor speech disorder making it difficult to speak clearly) following a stroke. The Minimum Data Set (a resident assessment tool) dated 11/10/2025, documented the resident was cognitively intact.Review of Resident #138's Comprehensive Care Plan dated 11/20/2025 revealed a communication problem related to dysarthria/Parkinson's disease and used psychotropic medications related to anxiety and depression. Interventions included, but were not limited to, allowing adequate time for the resident to respond, repeating information as needed, refraining from rushing the resident, making eye contact, using simple and brief words or alternative communication tools as needed, provide simple explanations and step-by-step instructions before interactions, and to ask for the resident's assistance rather than telling them what to do. During an observation on 12/12/2025, at 8:41 AM., an unknown staff member entered Resident #138's room without knocking or announcing their presence. When interviewed at that time, Resident #138 stated staff sometimes entered the room without speaking, completed tasks, and left without communicating.During an observation on 12/18/2025, at 12:05 PM., Certified Nursing Assistant #1 entered Resident #138's room carrying the resident's meal tray without knocking or announcing their presence. Certified Nursing Assistant #1 did not communicate with the resident during the interaction, placed the meal tray at the foot of the bed, and removed personal items from the bedside table without discussing the action with the resident or asking for the resident's preference. When interviewed at that time, Certified Nursing Assistant #1 stated it was their usual practice to ask permission to enter a resident's room and to interact with residents during care, but they did not provide an explanation for why those actions did not occur during the observed interaction.During an interview on 12/18/2025 at 12:10 PM, Resident #138 stated they preferred staff ask permission before entering the room and before moving personal items.During an interview on 12/18/2025 at 12:52 PM, Registered Nurse Manager #2 stated they expected staff to knock before entering a resident's room and ask permission to enter.During an interview on 12/19/2025 at 11:46 AM, the Director of Health Services stated staff were expected to knock before entering resident rooms, introduce themselves, communicate with residents during care, and ask questions and offer options prior to completing tasks.10 NYCRR 415.5(a)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, review conducted during recertification and complaint (#2691821) surveys from 12/11/2025 to 12/19/2025, the facility failed to ensure residents were free of significant medication errors for three (3) of six (6) residents reviewed (Residents #33, #88, #154). Specifically, Resident #33 received insulin outside of administration parameters included in the medical order. Resident #88 received insulin outside of administration parameters included in the medical order and received insulin without documented evidence a blood glucose measurement was obtained prior to administration. Resident #154 did not receive medications and treatments in accordance with physician orders for multiple days after returning to the facility following a hospitalization. The findings include:The facility policy Medication Administration, Documentation, and Premedication revised August 2024 included, but was not limited to, licensed nursing staff were to check for hold parameters for medications, check laboratory values prior to administering any medications with ordered hold parameters and documents results prior to administration. 1. Resident #154 had diagnoses including Parkinson's disease with dyskinesia (a movement disorder of the nervous system with involuntary uncontrollable movements), localized edema (tissue swelling), and difficulty walking. The Minimum Data Assessment (a resident assessment tool) dated 09/19/2025 revealed the resident was cognitively intact. Review of Resident #154's electronic medical record from 12/04/2025 to 12/10/2025 revealed the following:- In a nursing progress note dated 12/05/2025 at 4:28 PM, Registered Nurse Supervisor #1 documented Resident #154 was transferred to the hospital for evaluation following a fall.- In a nursing progress note dated 12/06/2025 at 10:34 AM, Licensed Practical Nurse #3 documented Resident #154 returned from the hospital.- A hospital after-visit summary dated 12/06/2025 at 7:47 AM, indicated no new medications were prescribed during the emergency department visit and instructed the facility to follow up with Resident #154's primary care provider regarding continuation of medications.- In a nursing progress note dated 12/10/2025 at 3:52 PM, Registered Nurse Supervisor #1 documented Resident #154 had not received any prescribed medications since returning from the hospital. Review of the Medication and Treatment Administration Records from 12/06/2025 through 12/10/2025 revealed Resident #154's previously prescribed medications and treatments were placed on hold and not administered on these consecutive days following the resident's return from the hospital, including:- Carbidopa-levodopa 20-100 milligrams, 1.5 tablets once in the morning at 6:00 AM and one (1) tablet in the afternoon at 1:00 PM daily for Parkinson's disease (ordered on 10/01/2024).- Hydrochlorothiazide 12.5 milligrams, once daily at 6:00 AM for localized edema (ordered on 10/01/2024).- Apply below the knee TED stockings (compression stockings used to help control leg swelling), applied to both legs in the morning at 6:00 AM and taken off both legs in the evening. There was no documented evidence the medications were discontinued by a medical provider, or if the primary care provider was contacted to clarify continuation of orders. During an interview on 12/19/2025 at 10:35 AM, Licensed Practical Nurse Clinical Coordinator #1 stated when a resident returns from the hospital, medications and treatments are expected to be resumed unless there is documentation in the hospital discharge paperwork indicating otherwise. During an interview on 12/19/2025 at 11:14 AM, Registered Nurse Manager #1 stated Resident #154 had returned from the hospital and was on the unit from 12/06/2025 to 12/10/2025, medications were not given during this time, and missing medications used to treat Parkinson's disease could place the resident at increased risk for falls with injuries. 2. Resident #88 had diagnoses including diabetes, dementia, and high blood pressure. The Minimum Data Set, dated [DATE] revealed the resident had severe cognitive impairment. Review of current physician orders revealed Resident #88 was prescribed the following:- Humalog insulin (a fast-acting insulin given with meals), six (6) units two (2) times daily at lunch and dinner for hyperglycemia, hold for blood glucose less than 105 milligrams/deciliter (ordered on 12/05/2025).- Finger-stick blood glucose before meals. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For blood glucose less than 80 milligrams/deciliter or greater than 300 milligrams/deciliter, place in medical book. For blood glucose greater than 400 milligrams/deciliter or under 70 milligrams/deciliter, call medical (ordered on 03/26/2025). Review of Resident #88's Medication Administration Records, Treatment Administration Records, blood glucose monitoring records, progress notes, and medication administration audit reports from 10/01/2025 to 12/18/2025 revealed the following: - On 10/07/2025, the resident's blood glucose was 73 milligrams/deciliter at 11:03 AM; six (6) units of Humalog were administered at 12:18 PM with no documented evidence of a repeat blood glucose measurement or interventions for low blood glucose.- On 10/15/2025, the resident's blood glucose was 60 milligrams/deciliter at 11:36 AM; six (6) units of Humalog were administered at 12:33 PM with no documented evidence of a repeat blood glucose measurement or corrective intervention.- On 11/05/2025, six (6) units of Humalog were administered at 10:56 AM without documented evidence a blood glucose measurement was obtained prior to administration.- On 12/11/2025, six (6) units of Humalog were administered at 12:40 PM without documentation of a blood glucose measurement at lunchtime as ordered. During an interview on 12/18/2025 at 1:28 PM, Licensed Practical Nurse #5 stated a resident's blood glucose should be checked within 30 minutes of a meal if they are receiving mealtime insulin and insulin should never be given without checking the blood glucose first. During an interview on 12/19/2025 at 11:00 AM, Licensed Practical Nurse #1 stated a resident's blood glucose should be checked within 30 minutes but no more than 45 minutes before a meal when mealtime insulin was ordered. During an interview on 12/19/2025 at 11:57 AM, Registered Nurse Manager #1 stated insulin should be administered within 10 minutes of checking a resident's blood glucose. During an interview on 12/19/2025 at 1:25 PM, Medical Director #1 stated they would expect a blood glucose measurement be obtained closer to the time of insulin administration. During an interview on 12/19/2025 at 3:19 PM, the Director of Health Services stated a blood glucose measurement should be taken within 30 minutes of a meal but no more than 45 minutes when mealtime insulin was to be administered. They stated if checked more than 45 minutes prior, it should be rechecked before administering insulin. 3. Resident #33 had diagnoses including diabetes mellitus, pneumonia and heart failure. The Minimum Data assessment dated [DATE] revealed the Resident was cognitively intact. Review of current physician orders dated 11/25/2025 revealed Resident #33 was prescribed the following:- Humalog insulin, four (4) units before meals. Nutritional baseline insulin, in addition to sliding scale coverage per blood glucose result. Hold if blood glucose is less than 100 milligrams/deciliter and/or patient is not eating. - Finger-stick blood sugar (glucose) before meals and at bedtime. For blood glucose less than 80 milligrams/deciliter or greater than 250 milligrams/deciliter place in medical book. For blood glucose greater than 500 milligrams/deciliter call medical. Review of Resident #33's Medication Administration Records, Treatment Administration Records, blood glucose monitoring records, progress notes, and medication administration audit reports from 12/01/2025 to 12/18/2025 revealed on 12/12/2025 at 11:30 AM, the resident's blood glucose was 91 milligrams/ deciliter, and four (4) units of Humalog were administered despite the ordered hold parameter. During an interview on 12/19/2025 at 12:19 PM, Licensed Practical Nurse Clinical Coordinator #2 stated if Resident #33's blood glucose value was 91 milligrams/ deciliter insulin should have been held, the medical provider notified in the medical provider communication book, and the nurse manager notified. During an interview on 12/19/2025 at 12:27 PM, the Registered Nurse Manager #4 stated nursing staff were expected to follow blood glucose and insulin orders as prescribed. Registered Nurse Manager #4 stated insulin should not have been administered if Resident #33's blood glucose was 91 milligrams/deciliter. During an interview on 12/19/2025 at 1:44 PM, the Director of Health Services stated nursing staff were expected to follow blood glucose and insulin orders as prescribed, including administration parameters. 10 NYCRR 415.12(m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure medications were stored securely and accessible only to authorized personnel, in accordance with professional standards of practice and State and Federal regulations, for two (2) of four (4) residential units reviewed ([NAME] Place and [NAME] Place). Specifically, multiple loose pills (unsecured medications that were not contained in labeled packaging) were observed in medication carts, and a medication cart was observed unlocked and unattended.The findings include:Review of facility policy Medication Storage revised [DATE] included, but was not limited to, all medications stored and used within the facility shall be properly labeled and securely stored. Licensed nursing staff ensure expired, discontinued, or contaminated medications are removed promptly and disposed of according to facility policy and applicable regulations. Review of facility policy Medication Administration, Documentation, and Premedication revised [DATE] included, but was not limited to, all medication carts are to be locked when not being used and not under direct observation by the assigned nurse. Medications are not to be left unattended. During an observation on [DATE] at 10:27 AM, on the [NAME] Place Unit, a medication cart was inspected and found to have 29 loose pills lying unsecured in the bottom of the second drawer of the cart. Medications included, but were not limited to, anticoagulant, antidepressant, and antihypertensive medications. When interviewed at that time, Licensed Practical Nurse #2 confirmed responsibility for the medication cart and stated medication carts were checked by nursing staff weekly during their shifts and nurses were to notify the nurse manager if loose pills were found and needed to be discarded. During an observation on [DATE] at 4:03 PM, on the [NAME] Place Unit, a medication cart was inspected and found to have one (1) loose pill unsecured within the second drawer of the cart. When interviewed at that time, Licensed Practical Nurse #4 confirmed responsibility for the medication cart and stated medication carts were checked by nursing staff each shift and loose pills should be discarded either by flushing down the sink or putting in a sharps container (a puncture-resistant, leak-proof container for safely disposing sharp medical waste). During an observation on [DATE] at 10:22 AM, on the [NAME] Place Unit, a medication cart assigned to Licensed Practical Nurse #3 was inspected and found to have two (2) loose pills in the drawers of the cart. During an observation on [DATE] at 8:37 AM, on the [NAME] Place Unit, a medication cart was unlocked and unattended in the hallway with a bottle of eye drops setting on top of the cart. There was no licensed nursing staff present at or supervising the medication cart. The cart remained unattended for approximately two (2) minutes, during which time a resident was observed ambulating past the medication cart. During an interview on [DATE] at 10:16 AM, the Director of Health Services stated nursing staff were responsible for routine upkeep of medication carts and nurse managers were expected to conduct routine checks to ensure medications were stored and accounted for appropriately.10 NYCRR 415.18(e)(1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the Recertification Survey from 12/11/2025 through 12/19/2025, the facility did not ensure they established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (3) (Residents #11, #69, and #184) of six (6) residents reviewed. Specifically, Resident #11 had catheter care performed, the new drainage bag was observed on the floor uncovered and a nurse stepped on it. Resident #69 was on transmission based precautions (an infection control strategy used to control the spread of air-borne infections) and staff were observed going into the resident's room without wearing personal protective equipment (such as mask, gown, and gloves, worn to protect individuals and staff and reduce the risks of exposure to and spread of infections). Resident #184 was on enhanced barrier precautions (an infection control strategy that uses gloves and gowns during high contact resident care to reduce the spread of infection) and a staff member was observed providing therapy services with the resident and the staff was not wearing appropriate personal protective equipment. The facility policy Transmission-Based Precautions NS-25R, reviewed 07/18/2025, included facemasks were to be used upon entry into a member's room with respiratory droplet precaution, enhanced barrier precautions included the use of gown and gloves during high-contact member care activities for members with wounds, and an example of high-contact member care included transferring. The facility Droplet Precautions sign included standard precautions of wearing eye protection and gloves and/or gown, to put on a face mask before entering the room. The facility Enhanced Barrier Precautions sign included providers, and staff must wear gloves and a gown for high-contact resident care activities including transferring. The facility policy Urinary Catheter Insertion/Maintenance and Removal, dated September 2022, included the procedure of changing a urinary catheter bag, ensuring that the catheter bag was positioned below the level of the bladder and attached to either the resident's leg, bed frame or wheelchair. 1. Resident #69 had diagnoses including dementia, hemiparesis (one-sided muscle weakness), and prostatic hyperplasia (the enlargement of the prostate gland, leading to urinary symptoms). The Minimum Data Set (a resident assessment tool) dated 10/16/2025 revealed the resident was cognitively intact. In a progress note dated 12/11/2025 at 6:03 PM, Nurse Practitioner #2 documented that they saw Resident #69 on 12/11/2025 for a temperature of 101 degrees Fahrenheit, chills and rigors (rising body temperature accompanied by severe shivering) with the cause of the illness unknown. During and observation and interview on 12/12/2025 at 10:48 AM, Certified Nursing Assistant #6 entered Resident #69's room, which had a droplet precaution sign posted outside the room and was seen not wearing a mask, gown or eye protection while in the room. Additionally, personal protective equipment was observed inside the resident's room hanging from a caddy on the door. In an immediate interview, Certified Nursing Assistant #6 stated they would check the care plan to see if a resident was on isolation precautions, they did not wear a mask while in the resident's room, and knew they needed to wear a mask. During an interview on 12/12/2025 at 11:00 AM, Registered Nurse Manager #3 stated staff would know a resident was on precautions as a sign would be on the resident's room door and if the resident was on droplet precautions, personal protective equipment (masks, gowns, gloves, shield) would be outside the resident's room on the door. Registered Nurse Manager #3 said Resident #69 was on standard droplet precautions, and a regular mask, eye shield, gown, and gloves should be worn. 2. Resident #184 had diagnoses including a stage 3 pressure ulcer to the right ankle (a skin injury caused by pressure, characterized by full-thickness skin loss), unsteadiness on feet, and generalized muscle weakness. The Minimum Data Set, dated [DATE], included the resident was cognitively intact. Review of the Comprehensive Care Plan as of 11/04/2025, revealed Resident #184 was at risk for infection related to a chronic vascular ulcer (wound that develops on skin due to (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems with blood circulation) on their left medial malleolus (inner side of the ankle) and was on enhanced barrier precautions. Interventions included to initiate isolation precautions and for staff to wear appropriate personal protective equipment including a gown and gloves during high contact care. During an observation on 12/15/2025 at 2:22 PM, Physical Therapy Assistant #1 was in Resident #184's room which had enhanced barrier precaution signage on the door entering the room. Physical Therapy Assistant #1 was not wearing any personal protective equipment, was observed putting a gait belt (a device used to hold someone and prevent falls) around Resident #184's waist, moving an elastic band around the resident's thighs, adjusting the resident's shirt and pants, and touching objects in the resident's room including the tray table and wheelchair. In a Physical Therapy Treatment Encounter Note dated 12/15/2025, Physical Therapy Assistant #1 documented that Resident #184 transitioned to all surfaces within the room with contact guard assist (a technique used in occupational and physical therapy where the therapist maintains light, consistent physical contact with the patient throughout a movement as a safety measure) and stand by assist (a technique used in occupational and physical therapy where the therapist remains in close proximity to the patient but does not have direct contact with the patient). During an interview on 12/19/2025 at 12:46 PM, Physical Therapy Assistant #1 stated for residents on enhanced barrier precautions, if they saw personal protective equipment outside the door, they would wear a gown and mask if they were doing something in close contact with a urinary foley (a tube placed to drain fluid from the bladder), a wound or a tracheostomy (opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), and if they were in direct contact with skin or providing hygiene care. They did not think they would have to wear personal protective equipment if they were assisting a resident that was fully dressed. Physical Therapy Assistant #1 said they did not recall seeing the enhanced barrier protection sign for Resident #184's room, they did not wear any personal protective equipment while in the resident's room and acknowledged they put a gait belt around Resident #184. 3. Resident #11 had diagnoses including neurogenic bladder (a condition that affects bladder function), bacteremia (bacterial blood infection), and presence of a suprapubic catheter (a device that drains urine from the bladder through a hole in the abdominal wall.) The Minimum Data Set, dated [DATE] documented that the resident was mildly cognitively impaired. Review of the Comprehensive Care Plan on 12/15/2025 included that Resident #11 was at risk for infection due to having an indwelling catheter with interventions that included monitoring the resident for pain or signs of infection and enhanced barrier precautions. The Kardex (a care plan used by Certified Nursing Assistants for daily care) included to keep the catheter drainage bag below the bladder and off the floor, and wearing personal protective equipment for resident care. Review of current Physician orders as of 12/15/2025 included to change the urinary drainage bag weekly and as needed. During an observation and interview on 12/16/2025 at 02:10 PM, Registered Nurse #1 irrigated Resident #11's suprapubic catheter and changed their urinary drainage bag. Following the procedure, Registered Nurse #1 was observed to have let the new drainage bag rest on the floor uncovered and stepped on the new bag with their shoe. Registered Nurse #1 stated that they were not aware that they had stepped on the drainage bag and subsequently changed the resident's drainage bag. During an interview on 12/17/2025 at 10:06 AM, the Infection Preventionist stated a sign on the resident's room name plate would indicate if there were any enhanced barrier precautions or droplet precautions for that resident, and if therapy staff were holding on to a gait belt worn by a resident on enhanced barrier precautions, personal protective equipment should be worn. The Infection Preventionist said urine collection bags have a clip and are to be clipped to a wheelchair or bed, so they are not dragged on the ground. The Infection Preventionist stated Registered Nurse #1 thought the urine collection bag was where it was supposed to be (off the ground), and once they became aware they stepped on it, they did the correct thing and changed the bag. 10 NYCRR 415.19