STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335484	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Nursing and Rehabilitation Center	1000 Pelham Parkway South Bronx, NY 10461

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some 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 observation, record review, and interviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (1) resident (Resident #157) during Resident Council Meeting. Specifically, Resident #157's meal-time insulin order did not include specific hypoglycemia parameters; however, licensed nursing staff withheld scheduled meal-time insulin doses as ordered on multiple occasions despite parameters outlined by facility policy, without notifying or consulting the physician, and without documenting a clinical rationale. The findings include: The facility's policy titled, Diabetic Management, dated effective 05/2021, documented multiple procedures to manage residents with diabetes and to document such care. The procedure titled, Insulin Dependent Diabetic with Routine Insulin Orders and Sliding Scale, documented the responsible nurse performs finger stick and administers routine insulin as ordered. Additionally, the responsible nurse holds all rapid-acting medication if the resident will not consume the scheduled meal or snack and notify the medical doctor to obtain an order to hold the medication. The procedure titled, Emergency Diabetic Management, documented that physicians should be notified according to the parameters as specified with blood sugar testing orders. Additionally, it is the practice that any time there are hypo-or hyperglycemic reactions, the medical doctor is to be notified, and a repeat blood glucose is taken. The facility's policy titled, Hypoglycemia Protocol, dated effective 07/2014, documented that hypoglycemia is defined as a blood glucose result less than sixty (60) milligrams per deciliter. The policy stated that the protocol should not be used when residents' blood glucose is greater than sixty (60) milligrams per deciliter. Of the risk factors for hypoglycemia listed, insulin administration is included. The protocol includes that the physician should be consulted to determine if subsequent doses of insulin should be given or changed. Resident #157 was admitted to the facility with diagnoses including hypertension, diabetes mellitus and seizure disorder.The Minimum Data Set, dated [DATE] documented Resident #157's cognition is moderately impaired, and they received insulin injections daily. The Physician's Order for Insulin Lispro initiated on 03/05/2025 instructed to inject four (4) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. The Physician's Order for Insulin Lispro initiated on 04/09/2025 instructed to inject eight (8) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. The Physician's Order for Insulin Lispro initiated on 04/24/2025 instructed to inject four (4) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. The Medication Administration Record revealed Insulin Lispro was not administered for thirty-six (33) out of seventy-two (72) opportunities from 04/01/2026 to 04/24/2026. The blood glucose readings at the time of omitted doses ranged from sixty-four (64) milligrams per deciliter to two hundred and two (202) milligrams per deciliter. The electronic medical record was reviewed for entries of nurse notes for clinical rationale of omission of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	insulin lispro administration. From 04/01/2026 to 04/24/2026, code four (4) indicating vitals outside of parameter was documented for eleven (11) administration opportunities. There was no documented evidence that blood sugar levels for Resident #157 were less than sixty (60) milligrams per deciliter or more than three hundred (300) milligrams per deciliter for any insulin lispro administration time from 04/01/2026 to 04/24/2026. There was no documented evidence that a physician was notified of any blood sugar level out of parameter or for any concern to withhold insulin lispro administration. During an interview on 04/27/2026 at 11:16 AM, Registered Nurse #1 stated they work from 07:00 AM to 07:00 PM. Registered Nurse #1 stated Resident #157 has rapid-acting insulin prior to meals with blood glucose monitoring. Registered Nurse #1 stated they are responsible for checking blood glucose and administering insulin Lispro for lunch at 12:15 PM, as lunch service is at 12:30 PM, and for dinner at 05:15 PM, as dinner service is at 05:30 PM. Registered Nurse #1 admitted the order does not indicate parameters to hold the insulin Lispro order. However, Registered Nurse #1 stated if Resident #157's blood glucose is less than 140 milligrams per deciliter, they withheld the medication to prevent hypoglycemic episodes. Registered Nurse #1 stated they did not know that Resident #157's insulin Lispro order at 06:30 AM was not being carried out by the night shift nurse. Registered Nurse #1 stated they were not informed by the night shift nurse that Resident #157's insulin Lispro was withheld due to breakfast timing.During an interview on 04/28/2026 at 11:05 AM, Registered Nurse #8, the Nursing Supervisor, stated Resident #157 is to receive insulin Lispro with glucose monitoring prior to meals at 06:30 AM, 11:30 AM and 04:30 PM. The night shift nurse is responsible for checking the blood sugar, documenting it in the medication administration record, and endorsing it to next shift nurse that the sugar was taken. Day shift nurses will give insulin prior to breakfast but withhold if blood glucose level is below 70 milligrams per deciliter. Registered Nurse #8 stated they were not aware that Resident #157 did not receive insulin on multiple occasions without consulting with the Medical Doctor.During an interview on 04/27/2026 at 12:35PM, the Medical Doctor was interviewed over the phone and stated they could not recall nurses relating that insulin Lispro was withheld for Resident #157. Medical Doctor stated they are in the facility very often, so they are reviewing Resident #157s blood glucose trends and adjusting as needed.During an interview on 04/28/2026 at 12:34 PM, the Director of Nursing stated they were recently made aware of the concerns related to Resident #157's insulin management and incident of omitted insulin on 04/22/2026. The Director of Nursing stated they have already started the plan of correction to address this issue. 10 New York Codes, Rules and Regulations 415.12

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure that residents are free of significant medication errors. This was identified for one (1) resident (Resident #157) during Resident Council Meeting. Specifically, Resident #157 did not receive Insulin Lispro (a fast-acting meal-time insulin) prior to meals in accordance with the physician's order. Furthermore, the omission of several doses and the failure to notify the medical doctor potentiated increased risk of hypoglycemic episodes. The findings include: The facility's policy titled, Diabetic Management, dated effective 05/2021, documented multiple procedures to manage residents with diabetes and to document such care. The procedure titled, Insulin Dependent Diabetic with Routine Insulin Orders and Sliding Scale, documented the responsible nurse performs finger stick and administers routine insulin as ordered. Additionally, the responsible nurse holds all rapid-acting medication if the resident will not consume the scheduled meal or snack and notify the medical doctor to obtain an order to hold the medication. The procedure titled, Emergency Diabetic Management, documented that physicians should be notified according to the parameters as specified with blood sugar testing orders. Additionally, it is the practice that any time there are hypo-or hyperglycemic reactions, the medical doctor is to be notified, and a repeat blood glucose is taken. The facility's policy titled, Hypoglycemia Protocol, dated effective 07/2014, documented that hypoglycemia is defined as a blood glucose result less than sixty (60) milligrams per deciliter. The policy stated that the protocol should not be used when residents' blood glucose is greater than sixty (60) milligrams per deciliter. Of the risk factors for hypoglycemia listed, insulin administration is included. The protocol includes that the physician should be consulted to determine if subsequent doses of insulin should be given or changed. Resident #157 was admitted with diagnoses including hypertension, diabetes mellitus, and seizure disorder.The Minimum Data Set, dated [DATE] documented Resident #157's cognition is moderately impaired.On 04/23/2026 at 10:31 AM during the Resident Council Meeting, Resident #157 stated that they are diabetic and receive insulin, but their blood sugar was not checked the day before prior to meals.The Physician's Order for Insulin Lispro initiated on 03/05/2025 instructed to inject four (4) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. The Physician's Order for Insulin Lispro initiated on 04/09/2025 instructed to inject eight (8) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. The Physician's Order for Insulin Lispro initiated on 04/24/2025 instructed to inject four (4) units subcutaneously before meals for diabetes. Notify Medical Doctor if blood sugar is greater than four hundred (400) milligrams per deciliter. The order did not specify the blood sugar level hold parameter for concern of hypoglycemia. 1.The Medication Administration Record revealed that Insulin Lispro was not administered for twenty-one (21) out of twenty-four (24) opportunities for the 6:30 AM scheduled dose from 04/01/2026 to 04/24/2026. Code four (4) indicating vitals outside of parameter was documented for one (1) scheduled dose administration opportunity. Code five (5) indicating hold/see nurse notes was documented for four (4) scheduled dose administration opportunities. Code nine (9) indicating other/see nurse notes was documented for sixteen (16) scheduled dose administration opportunities. The electronic medical record was reviewed. Medication administration nurse notes reviewed from 04/01/2026 to 04/24/2026 revealed fifteen (15) out of twenty-one (21) omitted 6:30 AM insulin lispro scheduled doses were documented to be omitted as the breakfast meal was not ready. Additionally, three (3) out of the twenty-one (21) omitted 6:30 AM insulin lispro scheduled doses were omitted without documented rationale. There was no documented evidence that a physician was notified for a hold order or that insulin lispro was administered prior to the breakfast meal. The electronic medical record documented the nurse note on (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	04/13/2026 at 7:18 AM to include resident noted with finger stick ninety-three (93) milligrams per deciliter. Scheduled insulin was held due to blood glucose level and concern for hypoglycemia. Resident remains alert and oriented, not in any form of distress. There was no documented evidence that a physician was notified or consulted. A physician progress note dated 04/09/2026 documented that resident noted with elevated blood glucose. The note also stated the insulin dose would be increased. The physician's note failed to document monitoring parameters. A monthly physician note dated 04/15/2026 failed to include documented parameters for finger stick monitoring. A physician progress note dated 04/24/2026 documented decrease Admelog (insulin lispro) to four (4) units subcutaneously before meals due to low blood sugar. Continue to monitor glucose trends. The physician's note failed to include monitoring parameters. During an interview on 04/28/2026 at 08:59 AM, Registered Nurse #9 stated they work 07:00PM to 07:00 AM. Registered Nurse #9 stated Resident #157 is to receive standing dose of insulin Lispro prior to meal service. Therefore, Resident #157's blood sugar is checked at 06:30AM daily and endorsed to next shift nurse for administration because breakfast is not served until 07:30AM.2.The Medication Administration Record revealed on 04/21/2026 and 04/22/2026 Resident #157 did not receive any doses of insulin lispro. Additionally, there was no documented evidence that blood sugar levels were obtained prior to meals on 04/22/2026. Code four (4) indicating vitals outside of parameter was documented for two (2) scheduled dose administration opportunities on 04/21/2026 when the documented blood glucose levels were 140 and 142. Code five (5) indicating hold/see nurse notes was documented for one (1) scheduled dose administration opportunity. Code nine (9) indicating other/see nurse notes was documented for three (3) scheduled dose administration opportunities. The electronic medical record was reviewed. Medication administration nurse notes on 04/21/2026 did not document any clinical rationale for omission of insulin doses or evidence that the medical doctor was notified. Medication administration nurse notes on 04/22/2026 documented omission of insulin lispro doses at 6:35 AM to be due to breakfast meal was not ready, at 10:52 AM medication was not on hand and on order, and at 5:45 PM medication was not on hand. There was no documented evidence that a physician was notified for a hold order or that insulin lispro was administered prior to the breakfast meal. Additionally, there was no documented evidence that a nurse supervisor or medical doctor was notified of the medication being out of stock. During an interview on 04/23/2026 at 09:24 AM, Registered Nurse #6 stated they worked from 7:00 AM to 7:00 PM on 04/22/2026. Registered Nurse #6 stated that Resident #157 had insulin ordered to be given prior to meal service along with blood sugar levels to be taken. Registered Nurse #6 stated Resident #157 was not given insulin Lispro prior to lunch and dinner because it was out of stock, but they believe they did check Resident #157's blood sugar levels. Registered Nurse #6 stated medications should have been ordered in advance, so they don't run out of the medications. Registered Nurse #6 stated they are supposed to notify the Nursing Supervisor and the Medical Doctor when a resident's medication is out of stock. However, Registered Nurse #6 could not recollect if the Nursing Supervisor and Medical Doctor were notified.During an interview on 04/23/2026 at 09:01AM, Registered Nurse #5 stated they worked from 7:00 PM to 7:00 AM on 04/22/2026. Registered Nurse #5 stated Resident #157's blood sugar was checked at 06:30 AM but they did not administer the insulin because the breakfast meal started at 7:30 AM. Resident #157's blood sugar level was endorsed for next shift nurse to administer the Insulin Lispro prior to serving the breakfast meal. Registered Nurse #5 was not aware that Insulin Lispro was out of stock on 04/22/2026 and could not explain why the blood sugar level was not documented in the electronic medical record.During an interview on 04/28/2026 at 11:05 AM, Registered Nurse #8, the Nursing Supervisor, stated they should be notified immediately when medication runs out. Registered Nurse #8 can check to see if the stock is available in their emergency supply of medications. If it is not available in the emergency stock, the Medical Doctor would be consulted for further instructions. Registered Nurse #8 stated they worked from 8:00 AM to 8:00 PM on 04/22/2026 but were never notified about Resident #157 and insulin being out of stock by Registered Nurse (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	#6.During an interview on 04/28/2026 at 12:34 PM, the Director of Nursing stated they were recently made aware of the concerns related to Resident #157's insulin management and incident of omitted insulin on 04/22/2026. The Director of Nursing stated they have already started the plan of correction to address this issue. 10 New York Codes, Rules and Regulations 415.11(c)(3)(i)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure that it promoted and facilitated resident self-determination by supporting resident choice. Specifically, residents were not provided with showers twice a week per their bathing preference. This was evident for two (2) of three (3) residents (Resident #10 and Resident #108) reviewed for Choices out of a total of 38 sampled residents.The findings include: The facility's policy and procedure titled, Showers, dated effective 08/2020, documented each resident is to have a minimum of two baths or showers each week including shampoos. Unit nurses are responsible for monitoring the provision of resident showers on the assigned days, interviewing residents to determine the reason for any shower refusal, and making necessary adjustments or referrals. 1.Resident #108 has an active diagnoses including end stage renal disease, hemiplegia and cataract. The Annual Minimum Data Set assessment dated [DATE] documented Resident #108 was cognitively intact, required partial assistance for showering or bathing, and had not rejected care. The Annual Minimum Data Set also documented that it was somewhat important for Resident #108 to choose between a tub bath, shower, bed bath, or sponge bath. On 04/21/2026 at 10:33 AM, Resident #108 was interviewed and stated that they go to dialysis on Mondays, Wednesdays and Fridays. Resident #108 further stated that on the days that they return from dialysis they are too tired to receive showers and so they refuse it. Resident #108 stated that they had informed a nurse on the unit to switch their shower days to Tuesdays and Saturdays, instead of Wednesdays and Saturdays, as they were too tired on dialysis days to receive a shower. Resident #108 further stated that they have not been getting regular showers and that staff have offered various excuses as to why shower days cannot be changed. On 04/24/2026 10:36 AM, in a subsequent interview, Resident #108 stated that they were not offered showers on Saturday. Resident #108 stated that if they were offered showers, they would take one to freshen up and be clean. Resident #108 further stated that they do not prefer bed baths over showers, but it is easier for staff to provide them with bed baths as showers involve too much work for the staff including using the Hoyer lift to transfer Resident #108 for the shower. A care plan initiated for the resident has activities of daily living: self-care performance deficit related to diagnosis of end stage renal disease on hemodialysis, diabetes mellitus, anemia, history of right hemiplegia, cataract and other comorbidities was initiated on 01/24/2025. The care plan documented Resident #108 required partial/moderate assistance for showering and bathing self. The facility interventions included washing Resident #108's skin and hair with [NAME]-Shampoo/Body. The care plan did not document Resident 108's bathing preferences. There was no documented evidence in the nursing progress notes, behavioral notes or in the nursing episodic behavioral forms regarding Resident #108's refusal of showers for the month of March 2026 and April 2026. The Resident Kardex (a report containing resident care instructions that Certified Nursing Assistants (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must provide) as of 04/22/2026 documented Resident #108's shower schedule to be on Wednesdays and Saturdays from 3:00 PM to 11:00 PM and as needed. The Documentation Survey Report from 04/01/2026 to 04/22/2026 documented Resident #108 received a bed bath on 04/01/2026, 04/04/2026, 04/11/2026, 04/15/2026, 04/18/2026 and 04/22/2026 during the 3:00 PM to 11:00 PM shift. The Documentation Survey Report from 03/01/2026-03/31/2026 documented that Resident #108 received a bed bath on 03/04/2026, refused bed bath and shower on 03/11/2026, received a bed bath on 03/14/2026, was not applicable for bed bath or shower on 03/22/2026, and refused shower and bed bath on 03/28/2026 during the 3:00 PM to 11:00 PM shift. On 04/24/2026 at 10:47 AM, Registered Nurse #4 was interviewed and stated that Resident #108 goes to dialysis on Mondays, Wednesdays and Fridays. Shower days are scheduled in the evening from 3:00 PM to 11:00 PM on Wednesdays and Saturdays. Registered Nurse #4 further stated that they were not aware that Resident #108 had refused showers. On 04/24/2026 at 10:55 AM, Registered Nurse Supervisor #2 was interviewed and stated that they have not heard from staff or any residents regarding any shower related issues or concerns. On 04/24/2026 at 10:57 AM, Certified Nursing Assistant #13 was interviewed and stated that Resident #108 is supposed to get showers twice weekly in the evenings and had previously mentioned concerns regarding the shower schedule a couple of weeks ago. Certified Nursing Assistant #13 further stated that Resident #108 had stated to them that the scheduled time of their showers fall on dialysis days and they are too tired after dialysis to take a shower. Certified Nursing Assistant #13 stated that Resident #108 stated they would like different shower days that do not fall on dialysis days. Certified Nursing Assistant #13 stated that they had informed the nurse/nurse manager regarding this issue at that time but cannot recall the name of who they had reported it to. On 04/24/2026 at 3:01 PM, Certified Nursing Assistant #16 was interviewed and stated that they work the evening shift from 3:00 PM to 11:00 PM. When Resident #108 is assigned to them, they will usually give Resident #108 a bed bath because they refuse showers. On 04/24/2026 at 3:41 PM, Certified Nursing Assistant #14 was interviewed and stated that Resident #108 will frequently refuse showers and bed baths but could not provide the reason as to why the resident refused showers and bed baths. Certified Nursing Assistant #14 stated Resident #108 had not mentioned anything regarding dialysis and their preferred shower schedule. Certified Nursing Assistant #14 stated that Resident #108 refused both shower and bed bath on 04/18/2026, but they had accidentally documented that Resident #108 received a bed bath. Certified Nursing Assistant #14 stated that they had previously reported Resident #108's refusal of showers to the nurse on the unit. On 04/27/2026 at 10:40 AM, in a subsequent interview, Registered Nurse #4 stated that it is important for residents to have regular showers for hygiene purposes. If residents voiced concerns about showers, the staff would encourage them to take a shower. Despite encouragement, if residents still refused, the staff would offer bed bath. Residents' families would also be notified that there are refusals of showers, and a care plan would be made. If residents refuse showers, the Certified Nursing Assistant should tell the nurse on the unit who would make a note in the system. Then, it is escalated to the nursing supervisor and the doctor. The family would also be informed. There should also be an episodic note stating that they refused. Registered Nurse #4 further stated that if a resident voiced concern about the shower days, then the care plan would be updated to accommodate (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the change in schedule. On 04/27/2026 at 3:31 PM, Certified Nursing Assistant #15 was interviewed and stated that there are days when Resident #108 refuses showers and prefers bed baths. The Certified Nursing Assistant #15 stated that as per their knowledge, Resident #108's shower schedule has always been on Tuesdays and Saturdays. They were not aware of any different shower days. Certified Nursing Assistant #15 further stated that Resident #108 has told them that they are too tired after dialysis to get showers and so the preferred days were Tuesdays and Saturdays. Resident #108 must be transferred via Hoyer lift for showers. Certified Nursing Assistant #15 further stated that when Resident #108 refused showers, they would report it to the charge nurse who said they would document it in the system. Certified Nursing Assistant #15 further stated that they cannot recall all the names of the charge nurses to whom they reported Resident #108's shower refusals, as different ones are assigned to the unit. Certified Nursing Assistant #15 further stated that they have reported it to Registered Nurse #10 who is currently on the unit. On 04/27/2026 at 3:38 PM, Registered Nurse #10 was interviewed and stated that it's important for residents to receive showers for dignity and health reasons. Registered Nurse #10 stated that Resident #108 has not mentioned anything to them regarding showers or the shower schedule. Registered Nurse #10 further stated that they were not aware Resident #108 has refused showers, and staff has not informed them regarding Resident #108's refusal of showers. On 04/27/2026 at 3:53 PM, Unit Manager #1 was interviewed and stated that if a resident refused to shower, the Certified Nursing Assistant must report it to the nurse. The nurse will reapproach the resident and if there is still a refusal, the doctor and family will be notified. A progress note will be entered, and the resident will be reapproached at a later date. The nurse will document it in the system, and the care plan will be updated. If there is no documentation on resident refusal of showers, it is a problem as it evidences a lack of communication between the Certified Nursing Assistant and the Nurse. Unit Manager #1 further stated that they were not previously made aware of Resident #108's shower schedule concerns. On 04/28/2026 at 10:03 AM, Charge Nurse #1 was interviewed and stated that they work from 7:00 PM to 7:00 AM on most weekends, Friday to Sunday. They have been on the unit since October 2025. Charge Nurse #1 stated that there have been times where Resident #108 refused showers in the past and bed baths had been offered. If residents refuse care, then it is important to document residents' refusals. Charge Nurse #1 stated that when Resident #108 refused shower, they had documented it in the behavior note or in the episodic behavior form. Charge Nurse #1 further stated that they were not aware Resident #108 had an issue with shower days colliding with dialysis days. On 04/28/2026 at 10:05 AM, The Director of Nursing was interviewed and stated that providing residents with regular showers is important for dignity and resident comfort. If a resident refuses a shower, the Certified Nursing Assistant must notify the nurse so that they can get another staff to re-offer it to the resident. The reason as to why the resident is refusing should also be found and addressed by the facility if it is something the facility can address. The resident's family should also be notified, and shower refusal should be documented in the system. A progress note would be written and care plan updated to reflect the resident's refusal of showers. It is important to document resident's refusal of showers; otherwise, there is no evidence to prove that the resident was offered showers. The Director of Nursing stated that they were aware that Resident #108 refused showers in the past but did not know the reason showers were refused. (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Resident #10 was admitted to the facility with diagnoses including end stage renal disease, hyperlipidemia, and diabetes mellitus. The admission Minimum Data Set, dated [DATE] documented that it is very important for Resident #10 to choose between a tub bath, shower or sponge bath. The Quarterly Minimum Data Set, dated [DATE] documented Resident #10 is cognitively intact and dependent on staff for shower. Resident #10 did not reject care. During an interview with Resident #10 on 04/22/2026 at 11:02 AM, Resident #10 stated they were not receiving showers as per biweekly schedule. The care plan for Refusal, initiated 03/03/2026, documented Resident #10 refused shower on 11/11/2025. Interventions included allowing resident to verbalize cares/concerns regarding care needed, encourage family in plan, establish routine and reinforce the importance of care needed. The Certified Nursing Assistant Instruction for Bathing, effective from 03/31/2026 to 04/22/2026 documented Resident #10's shower schedule is Tuesdays and Fridays during 3:00 PM to 11:00 PM shift and as needed. The Certified Nursing Assistant Documentation Record for Bathing, from 03/31/2026 to 04/22/2026 had no documented evidence Resident #10 received showers. The record documented Resident #10 received a bed bath on 03/31/2026, 04/03/2026, 04/07/2026, 04/10/2026, 04/17/2026, 04/21/2026 during 3:00 PM to 11:00 PM shift. No bed bath or shower was provided on 04/14/2026. The Nursing Notes dated from 03/31/2026 to 04/22/2026 revealed no documented evidence that Resident #10 received or refused showers. During an interview on 04/24/2026 at 09:37 AM, Certified Nursing Assistant #3 stated a resident's shower schedule can be found in their electronic system and on the shower schedule sheet at the nursing station. Certified Nursing Assistant #3 stated Resident #10 was given bed bath on 03/31/2026, 04/10/2026 because shower was refused. Certified Nursing Assistant #3 further stated that the nurse should be informed when any care is refused but they could not recall if the nurse was notified on those days. During an interview on 04/24/2026 at 09:43 AM, Certified Nursing Assistant #5 stated it was about 10:30 PM when Certified Nursing Assistant #5 realized shower was not done in accordance with schedule shown in the plan of care record for Resident #10. Certified Nursing Assistant #5 documented that shower was not applicable because it was too late to provide the shower. Certified Nursing Assistant #5 could not recall if unit nurse was notified of the shower not being done on that day. During an interview on 04/24/2026 at 10:40 AM, Certified Nursing Assistant #4 stated Resident #10 has shower scheduled every Wednesday and Saturday during 07:00 AM to 03:00 PM shift. Resident #10 has refused shower in the past so Certified Nursing Assistant #4 has been providing bed baths on their shower days. Certified Nursing Assistant #4 stated that on 04/22/2026, Resident #10 could not be showered or provided with bed bath because Resident #10 went out on an appointment and did not return until after 11:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335484	A. Building B. Wing	04/28/2026

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Morningside Nursing and Rehabilitation Center	1000 Pelham Parkway South Bronx, NY 10461

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2026 at 10:53 AM, Licensed Practical Nurse #1 stated Certified Nursing Assistants are responsible for providing shower/bed bath in accordance with residents' bathing schedules. Licensed Practical Nurse #1 stated that Certified Nursing Assistants are giving bed baths to Resident #10 because the resident refused showers which have been documented in the task completion record. Licensed Practical Nurse #1 stated Certified Nursing Assistants should notify Licensed Practical Nuse #1 when both shower/bed bath are refused by the resident. Licensed Practical Nurse #1 stated they probably were not notified because Resident #10 had been receiving bed baths on bathing days. During an interview on 04/24/2026 at 11:21 AM, Registered Nurse #7 stated they were not aware that Resident #10 was receiving bed baths in lieu of showers. Registered Nurse #7 stated Certified Nursing Assistants are responsible for informing unit nurses when residents refuse showers. During an interview on 04/28/2026 at 12:14 PM, Director of Nursing stated all residents are provided with showers twice a week and as needed, and schedules are determined by the room number. Certified nursing assistants are responsible for offering residents the shower in accordance with the shower schedule. When shower is refused, certified nursing assistants should notify unit nurses who will then interview the residents to determine the reason for refusal. Any adjustments will be implemented in the residents' care plans for staff to follow. During an interview on 04/28/2025 at 12:43PM, the Administrator stated Resident #10 had documented refused showers in the past in their care plan which are reviewed/discussed in interdisciplinary meeting every quarter. However, the Administrator could not provide documented evidence that this behavior of shower refusal is currently ongoing for Resident #10. 10 New York Codes, Rules and Regulations 415.5(b)(1-3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure that a person-centered comprehensive care plan was developed and implemented to address the residents' medical, physical, mental, and psychosocial needs. Specifically, a comprehensive care plan for a resident's hearing impairments was not developed and implemented. This was evident for one (1) resident (Resident #170) reviewed for Vision/Hearing out of a total of 38 sampled residents.The findings include: The facility policy and procedure titled, Care Planning Process, dated effective 07/2022, stated that the facility shall have a care planning process that is a person-centered which includes: integrating assessment findings in care planning, developing an interdisciplinary care plan, regularly reviewing and revising the care plan, as well as providing and documenting care. Resident #170 was admitted to the facility with diagnoses that included anemia, hypertension, and asthma (chronic obstructive pulmonary disease or chronic lung disease). The Annual Minimum Data Set, dated [DATE] documented Resident #170 has intact cognitive status, requires setup or clean-up assistance of staff for eating, oral and personal hygiene, upper body dressing, and requires partial/moderate assistance of staff for most other activities of daily living. There is no documented evidence of Speech Language Pathology and Audiology Services provided to Resident #170. On 04/21/2026 at 9:56 AM, Resident #170 was interviewed and stated that they have problems hearing well and they need to turn up the television very high to be able to hear a little bit now; Resident #170 stated that they have hearing aids but lost them, reported it to staff, but have not received replacement hearing aids. Physician's order dated 01/06/2026 documented, Consult: 'ENT:' Ear Nose Throat Consult for decreased hearing. Progress note, Medical, dated 04/15/2026 at 3:46 PM, documented that Resident #170 reports acute inability to hear in right ear, confirmed on assessment. Will consult Ear Nose Throat . acute Right ear hearing loss .Active Diagnosis and Treatment Plan: Right ear hearing loss . The electronic medical record for Resident #170 was reviewed. There is no documented evidence that a comprehensive care plan was developed or implemented for the care being provided for Resident #170's hearing impairment/hearing aids. On 04/24/2026 at 12:18 PM, Certified Nursing Assistant #1 was interviewed and stated that they have taken care of Resident #170 when assigned to the unit. Certified Nursing Assistant #1 stated that Resident #170 has problems hearing during care and has always complained of having difficulty hearing well. Certified Nursing Assistant #1 stated that they were not sure if Resident #170 has hearing aids and did not know if Resident #170 lost their hearing aids. On 04/24/2026 at 2:13 PM, Registered Nurse #1 was interviewed and stated that every time they go to Resident #170's room, Resident #170 would complain that it is difficult to hear very well since their hearing aids were missing. Registered Nurse #1 admitted that despite the resident's complaints, they (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	didn't know Resident #170 had hearing aids. Registered Nurse #1 further stated that residents' hearing aids are usually documented on Point Click under Certified Nursing Assistant Accountability Records (CNAAR). However, Registered Nurse #1 admitted they don't know how to check that documentation. Registered Nurse #1 stated that when Resident #170 reported difficulty hearing due to the missing hearing aids few days ago, it was reported to the Assistant Director of Nursing who ordered an ear consult. Registered Nurse #1 further stated that to initiate comprehensive care plan or episodic care plan, the nurse on the floor was supposed to complete an SBAR (Situation, Background, Appearance, Request or Recommendation) for the team to initiate a comprehensive care plan. Registered Nurse #1 could not explain why there was no comprehensive care plan initiated for Resident #170's hearing problem. On 04/24/2026 at 2:34 PM, the Supervisor, Registered Nurse #2, was interviewed and stated that based on chart review, Resident #170 was not admitted with hearing aids. Registered Nurse #2 stated that when Resident #170 verbalized having difficulty hearing, an Ear Consult was ordered on 04/15/2026. Resident #170 was seen by the consultant and earwax was removed from resident's ears. Registered Nurse #2 stated that they were not aware that Resident #170 did not have a care plan in place for hearing problems as they were not on the unit all the time and because Resident #170 was not noted with hearing problem upon admission. On 04/24/2026 at 2:42 PM, the Assistant Director of Nursing was interviewed and stated that they are not aware that Resident #170 has hearing aids; the Assistant Director of Nursing stated that an Ear-Nose-Throat (ENT) consultation was ordered on 04/15/2026 when Resident #170 complained of difficulty hearing. The resident was seen by the consultant on 04/22/2026, ear wax was reportedly removed, and documentation revealed that resident's ear examination was within normal limits with no new order given. The Assistant Director of Nursing stated that they did not realize that there was no comprehensive care plan documented for Resident #170's hearing impairment yet. The Assistant Director of Nursing was unable to state why there was no care plan initiated for Resident #170's hearing impairment. On 04/27/2026 at 10:56 AM, The Director of Nursing was interviewed and stated that if there are acute changes of condition for residents, the nurses on the unit should check, address the problem, and initiate the care plan to ensure that the problem is resolved. The Director of Nursing stated that they believe that Resident #170's care plan for hearing problems should have been initiated immediately when Resident #170 complained of hearing problems. The Director of Nursing stated that they were surprised that a care plan was not in place to address Resident #170's hearing impairments. 10 New York Code, Rules and Regulations 415.11(c)(1)