STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335493	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concourse Rehabilitation and Nursing Center Inc	1072 Grand Concourse Bronx, NY 10456

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 45351 Based on observation, record review, and interviews conducted during the recertification survey from 4/6/2024 to 4/12/2024, the facility did not ensure the results of the most recent facility survey were posted in a place readily accessible to residents, and family members and legal representatives of residents. This was evident for 12 of 12 residents (Resident #s 5, 11, 41, 64, 77, 129, 146, 188, 203, 209, 215, and 295) during the Resident Council Meeting. Specifically, there were no observations of posted survey results in the facility. The findings are: During the Resident Council Meeting on 4/8/2024 at 10:30 AM, Resident #s 5, 11, 41, 64, 77, 129, 146, 188, 203, 209, 215, and 295 stated they were not aware of the location of the facility's posted survey results. On 4/8/2024 at 11:50 AM, the 6th Floor was observed with a posting documenting the New York State Department of Health survey results were located on the 1st Floor bulletin board outside the Admissions Office. There were no other observations of a posting providing the location of the facility's survey results. On 4/8/2024 at 11:53 AM, the 1st Floor Admissions Office was observed without a bulletin board in the vicinity. There were no observations of posted survey results readily accessible to residents, family members, and resident legal representatives throughout the 1st Floor and all other areas of the facility. On 4/10/2024 at 12:17 PM, the Director of Admissions was interviewed and stated the 1st Floor bulletin board was removed during renovations and was never replaced after the construction. They were not aware a sign was posted on the 6th Floor indicating the facility's survey results could be found on the bulletin board. The Director of Admission stated the posting needed to be updated and the survey results needed to be accessible to all residents. On 4/12/2024 at 1:25 PM, the Director of Nursing stated survey results used to be posted on the bulletin board outside of the Admissions Office until recently. The survey results were no longer posted on the bulletin board or anywhere else in the facility. 415.3 (d)(1)(v)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, record review, and interviews conducted during a Recertification and Abbreviated (NY00331425) survey from 4/7/2024 to 4/12/2024, the facility did not ensure all alleged violations involving abuse were reported to the New York State Department of Health immediately or within 2 hours after the allegation was made. This was evident for 2 (Resident #80 and #119) of 38 total sampled residents. Specifically, 1) Resident #80 had a fall resulting in a fracture that was not reported to the New York State Department of Health, and 2) Resident #119 had an unwitnessed fall resulting in a fracture that was not reported to the New York State Department of Health. The findings are: The facility policy titled Prevention of Mistreatment, Neglect and Abuse and Misappropriation of Resident Property dated 10/4/2022 documented the Director of Nursing will report any accident or incident where there is reasonable cause to believe that resident abuse occurred to the New York State Department of Health. The facility policy titled Accident Prevention and Reporting dated 6/2023 documented the Director of Nursing reported any suspected incidence of abuse, neglect, or mistreatment to the New York State Department of Health. 1) Resident #80 had diagnoses of dementia and seizure disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #80 had moderately impaired cognition and required the assistance of 1 person for rolling in bed. The facility Accident Report dated 1/10/2024 documented Resident #80 fell out of bed during care when Certified Nursing Assistant #1 rolled the resident to one side and was unable to hold onto the resident. Resident #80 sustained a left femoral (thigh bone) fracture as a result of the fall. There was no documented evidence Resident #80's fall and fracture were reported to the New York State Department of Health. 2) Resident #119 had diagnoses of congestive heart failure and anxiety disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #119 was moderately cognitively impaired and required extensive assistance of 2 people for transfers and personal hygiene. The facility Accident Report dated 3/4/2024 documented staff heard a scream coming from Resident #119's room. Upon entering the room, Resident #119 was found on the floor with their left leg rotated inwards. Resident #119 was found to have a left fibula (ankle) and tibia (shin bone) fracture. There was no documented evidence Resident #119's fall and subsequent fracture was reported to the New York State Department of Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/2024 at 11:06 AM, an interview conducted with the Director of Nursing who stated allegations of abuse were reported immediately to the New York State Department of Health. The Director of Nursing stated they investigated abuse allegations within the first 2 hours of the occurrence and ruled out abuse before deciding if they needed to be reported to the New York State Department of Health. Resident #80's fall and fracture were not reported because it was a witnessed fall. Resident #119's fall and fracture were not reported because the resident was able to give an account of the incident that took place. 10 NYCRR 415.4(b)(2)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on record review and interviews conducted during a Recertification survey from 4/7/2024 to 4/12/2024, the facility did not ensure that the baseline care plan was developed within 48 hours of a resident's admission and the resident and/or their representative were provided with a written summary of the baseline care plan. This was evident for 1 (Resident # 10) of 38 total sampled residents. Specifically, the baseline care plan was not completed within 48 hours of Resident #10's admission to the facility and a copy was not provided to Resident #10. The findings are: The facility policy titled Baseline Care Plan dated 9/2023 documented a baseline care plan will be developed within 48 hours of resident's admission and the resident and their representative will be provided with a summary of the baseline care plan prior to the completion of the comprehensive care plan. Resident #10 was admitted to the facility on [DATE] with diagnoses of unspecified convulsions and acute osteomyelitis of the left ankle and foot. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #10 was moderately impaired in cognition participated in the assessment. On 4/07/2024 at 10:02 AM, Resident #10 was interviewed and stated they were not provided with a copy of their baseline care plan from admission to the facility approximately 4 months ago. The Baseline Care Plan for Resident #10 created on 11/21/2023 documented a completion date of 11/24/2023, more than 48 hours after the resident's admission to the facility on [DATE]. There was no documented evidence a copy of the baseline care plan was provided to Resident #10. On 4/10/2024 at 10:27 AM, Registered Nurse #1 was interviewed and stated they were responsible for creating and ensuring the completion of baseline care plans. Residents and their representatives were provided with a copy of the baseline care plan upon its completion. Registered Nurse #1 was not aware and was unable to provide an explanation for Resident #10 not receiving a copy of their baseline care plan. The baseline care plan for Resident #10 was completed 4 days after their admission to the facility. Registered Nurse #1 stated they provided a copy to Resident #10 but had no documented evidence that a copy had been provided. On 4/10/2024 at 12:35 PM, the Director of Nursing was interviewed and stated the unit nurse manager was responsible for overseeing the completion of baseline care plans within 48 hours of a resident's admission to the facility and documented in the medical record that a copy was provided to the resident and/or their representative. The Director of Nursing had no explanation for a copy of the baseline care plan not being provided to Resident #10. 10 NYCRR 415.11 (c)

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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** 44843 Based on record review and interviews conducted during the Recertification survey from 4/7/2024 to 4/12/2024, the facility did not ensure that a person-centered comprehensive care plan was developed and implemented to address the resident's medical, physical, mental, and psychosocial needs. This was evident for 1 (Resident #24) of 38 total sampled residents. Specifically, a comprehensive care plan was not developed and implemented for Resident #24's use of antipsychotic medication. The findings are: The facility policy titled Comprehensive & Interim Care Plan dated 8/10/2023 documented that a care plan is developed for each resident's problem, with a measurable goal and interventions necessary to achieve the goal. Resident #24 had diagnoses of delusional disorder and bipolar disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident # 24 was moderately impaired in cognition and received antipsychotic medication. The Physician Order dated 3/10/2024 documented Resident #24 received Quetiapine 50 milligrams once daily. The Medication Administration Record for March 2024 Resident #24 received Quetiapine 50 milligrams daily in accordance with the Physician Order. There was no documented evidence a comprehensive care plan was developed for Resident #24's use of Quetiapine, an antipsychotic medication. On 4/09/2024 at 11:48 AM, Registered Nurse #2 was interviewed and stated they were responsible for developing, reviewing, and updating comprehensive care plans upon admission, quarterly, and as needed. Resident # 24 was prescribed and administered the antipsychotic medication Quetiapine to treat behavioral symptoms. Registered Nurse #2 stated there should be a care plan for Resident #24's antipsychotic medication use and it was an oversight that one was not developed and implemented. On 4/09/2024 at 12:23 PM, the Director of Nursing was interviewed and stated the unit nurse manager was responsible for developing, reviewing, and updating the comprehensive care plans for each resident upon admission, quarterly, and as needed. A care plan should be developed for residents taking antipsychotic medication. The Director of Nursing was unable to locate a care plan for Resident #24's antipsychotic medication use and was not aware that one had not been developed. 10 NYCRR 415.11(c)(1

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, record review and interviews conducted during the recertification survey from 4/7/2024 to 4/12/2024, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers. This was evident for 1 (Resident #27) of 6 residents reviewed for pressure ulcers out of 38 total sampled residents. Specifically, Resident #27 was observed without on multiple occasions resident #27 was observed without heel float boots, a pressure-relieving device, in accordance with the Physician's Order. The findings are: The facility policy titled Pressure Ulcers dated 10/2023 documented assistive devices were used to treat and prevent pressure ulcers. Bony prominences were protected as needed. Resident #27 had diagnoses of dementia and respiratory failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #27 was severely cognitively impaired and was dependent on staff to perform activities of daily living. On 4/08/2024 at 11:00 AM and 12:30 PM and 4/10/2024 at 10:55 AM and 12:45 PM, Resident #27 was observed out of bed to a recliner chair in the unit hallway. Resident #27 did not have bilateral heel float boots in place. The Braden Scale - Skin Breakdown Risk assessment dated [DATE] documented that the resident was at risk for pressure ulcers. The Physician's Order initiated 10/10/2023 and renewed 4/1/2024 documented Resident #27 was ordered to always wear bilateral heel float boots, only to be removed for hygiene care. The Comprehensive Care Plan related to skin integrity last reviewed 3/29/2024 documented off-load Resident #27's heels while the resident was in bed. On 4/10/2024 at 12:34 PM, an interview was conducted with Certified Nursing Assistant #2 who stated they were assigned to Resident #27 and applied bilateral heel float boots to the resident's feet when the resident was in bed. Resident #27's family requested the resident where shoes when out of bed and in the recliner. Certified Nursing Assistant #2 stated that their daily task list for Resident #27 did not include instruction on application of heel float boots. On 4/10/2024 at 12:50 PM, an interview was conducted with Licensed Practical Nurse #1 who stated Resident #27 was ordered to always wear bilateral heel float boots unless they were receiving skin hygiene checks during activities of daily living care. Resident #27's family brought in shoes for the resident to wear and Licensed Practical Nurse #1 informed the family the Medical Doctor needed to be informed before the resident could wear the shoes. Licensed Practical Nurse #1 stated they saw Resident #27 wearing the shoes yesterday and instructed Certified Nursing Assistant #2 to stop using the shoes and to apply the bilateral heel float boots. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/2024 at 3:24 PM, Registered Nurse #1 was interviewed and stated Resident #27 had previously had a sacral pressure ulcer that healed. Resident #27 was ordered to always wear bilateral heel float boots to prevent skin breakdown. Registered Nurse #1 could not explain the reason Certified Nursing Assistant #2 did not apply the bilateral heel float boots to Resident #27's feet in accordance with the Physician's Order. 4/11/2024 at 1:40 PM, the Director of Nursing was interviewed and stated Registered Nurses were responsible for monitoring the application of special devices, such as hell float boots. 10 NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 33315 Based on observation, record review, and interviews conducted during a Recertification and Abbreviated survey (NY00331425) from 4/6/2024 to 4/12/2024, the resident received inadequate supervision to prevent an accident. This was evident for one (Resident #80) of three residents reviewed for accidents out of 38 total sampled residents. Specifically, the plan of care did not clearly indicate Resident #80 required 2-person assistance with activities of daily living. Subsequently, Resident #80 fell and sustained a left distal femoral neck fracture (thigh bone broken at the knee) when Certified Nursing Assistant #1 rolled the resident on their side during care without a 2nd staff member's assistance. This resulted in actual harm to Resident #80 that was not immediate jeopardy. Finding is: The facility policy and procedure titled Fall Prevention and Management Program dated 8/2023 documented the staff will follow the resident fall prevention plan of care to ensure resident safety. Resident #80 had diagnoses of dementia and cerebrovascular accident (a stroke). The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #80 was rarely/never understood and exhibited moderate cognitive impairment. Resident #80 required substantial/maximal assistance where the helper does more than half of the effort when rolling in bed and performing personal hygiene. The Certified Nursing Assistant Accountability Record for 1/2024 documented Resident #80 was provided with bed mobility assistance a total of 30 times between 1/1/2024 and 1/10/2024. The record documented 10 out of the 30 times bed mobility was performed, Resident #80 scored a 4 in performance, indicating they were totally dependent, and a 3 in support provided, indicating 2-person assistance was required. In 8 out of the 30 times bed mobility was performed, Resident #80 scored a 3 in performance, indicating they required extensive assistance, and a 3 in support provided, indicating 2-person assistance was required. The facility Accident Report dated 1/10/24 documented Certified Nursing Assistant #1 notified Registered Nurse #1 that Resident #80 fell from the bed onto the floor during care. Certified Nursing Assistant #1 lost their grip on Resident #80 when they rolled the resident onto their right side and the resident fell . The Accident Report documented a risk management plan for staff to observe the care protocol for two staff to assist with total care residents. The facility Write-Up Form dated 1/11/2024 documented Certified Nursing Assistant #1 was suspended for 3 weeks due to Resident #80's fall during care resulting in a diagnosis of left femur fracture. The write-up form documented that Certified Nursing Assistant #1 must always follow the Certified Nursing Assistant records prior to giving care to any resident. A Nursing Note dated 1/10/2024 documented a left knee x-ray showed Resident #80 had a moderately displaced comminuted fracture of the distal femur supracondylar region (thigh bone broken at the knee). Resident #80 was transferred to the hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan related to activities of daily living initiated 2/7/2024 documented reposition Resident #80 in bed with total assistance every 2-4 hours using a turning sheet. There was no documented evidence Certified Nursing Assistant #1 was provided with definitive instruction to provide Resident #80 with 2-person assistance when performing activities of daily living. This resulted in Resident #80's fall and fracture on 1/10/2024 when Certified Nursing Assistant #1 rolled the resident in bed without a 2nd person to assist. During an interview conducted on 4/10/2024 at 4:33 PM, Certified Nursing Assistant #1 stated they provided Resident #80 with care on 1/10/2024. Certified Nursing Assistant #1 rolled the resident to one side to provide care and lost their grasp on the resident, causing Resident #80 to fall on the floor. Certified Nursing Assistant #1 stated they were unaware Resident #80 required 2 people to assist with activities of daily living as they were regularly assigned to Resident #80 prior to the incident and provided one person assistance to perform hygiene and bed mobility. On 4/11/2024 at 3:21 PM, an interview conducted with the Acting Assistant Director of Nursing who stated Certified Nursing Assistants checked the task list in the medical record for their assigned residents prior to providing care. Any changes in resident condition and care required were discussed during report given to the Certified Nursing Assistants prior to the start of their shift. The Acting Assistant Director of Nursing stated they did not supervise Certified Nursing Assistants by observing the care they provided to residents. Supervision took place by discussing and reinforcing the Certified Nursing Assistant's tasks and responsibilities with them during report. During an interview on 4/11/2024 at 11:06 AM, Director of Nursing #1 stated Certified Nursing Assistants were in-serviced and performed competencies regarding their responsibility for checking the Accountability Record in the medical record prior to performing tasks with residents. Resident #80 required 2-person assistance at the time of the incident on 1/10/2024. Certified Nursing Assistant #1 did not follow protocol for performing activities of daily living and was taken off the schedule until the investigation was completed. During an interview on 4/12/2024 at 11:03 AM, the Rehabilitation Director stated Resident #80 required the extensive assistance of two people to perform activities of daily living prior to their fall on 1/10/2024. During an interview on 4/10/2024 at 2:41 PM, Medical Doctor #1 stated they were aware Resident #80 had a fall and fracture on 1/10/2024. Resident #80 was non-ambulatory prior to the fall incident and their activity of daily living status did not significantly change upon readmission from the hospital. 10 NYCRR 415.12(h)(2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review, and interviews conducted during the recertification survey from 4/7/2024 to 4/12/2024, the facility did not ensure dental services were provided from an outside resource to meet the needs of the resident. This was evident for 1 (Resident #203) of 38 total sampled residents. Specifically, the facility did not obtain outside dental services for Resident #203 when a tooth extraction was recommended. The findings are: The facility policy titled Dental Consultation dated 8/2023 documented residents were provided access to dental consultations as part of their comprehensive primary care. Resident #203 had diagnoses of diabetes mellitus and heart failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #203 was moderately cognitively impaired. On 4/10/2024 at 12:42 PM, Resident #203 was interviewed and stated a Dentist saw them in the facility a few months ago and recommended a tooth extraction. The facility did not assist with scheduling an appointment to have the tooth extraction and Resident #203's son coordinated with an outside dentist for an appointment. Resident #203 went to the outside dentist and the tooth extraction was not done because of an insurance issue. The facility has not assisted with any follow-up appointments with the dentist and the tooth extraction still was not addressed. The Comprehensive Care Plan related to dental care dated 1/13/2024 documented Resident #203 was at risk for a dental condition and should be referred for dental services. The Dental Consult dated 2/14/2024 documented Resident #203 complained of lower right mouth pain. Resident #203 had a broken tooth and the Dentist recommended Resident #203 have a tooth extraction. There was no documented evidence a Dental Consult for tooth extraction was ordered in response to the Dentist's recommendation on 2/14/2024. The Nursing Note dated 3/12/2024 documented Resident #203's son visited and informed the Nursing staff they made an appointment for Resident #203 to see an outside Dentist on 3/22/2024. The Physician's Order dated 3/12/2024 documented Resident had a Dentist appointment scheduled for 3/22/2024. The Nursing Note dated 3/22/2024 documented Resident #203 returned from their Dentist appointment and was not evaluated for tooth extraction because of an insurance issue. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence a follow-up Dentist appointment was scheduled when Resident #203 was not evaluated for tooth extraction on 3/22/2024. There was no documented evidence the facility assisted with alternative Dental arrangements or sources of payment for Resident #203 to receive a tooth extraction. On 4/10/2024 at 9:29 AM, Unit Clerk #1 was interviewed and stated they recall Resident #203's son made an appointment for the resident to be seen by a Dentist outside the facility. Resident #203 did go to the appointment on 3/22/2024 but was not seen by the Dentist due to an insurance issue. On 4/10/2024 at 12:59 PM, Registered Nurse #3 was interviewed and stated they were aware Resident #203 attempted to see an outside Dentist on 3/22/2024 but was not seen due to an insurance issue. Another Dental Consult was ordered for Resident #203, but Registered Nurse #3 did not know if the resident received any follow-up appointment yet. On 4/11/2024 at 11:56 AM, Medical Doctor #3 was interviewed and stated they were not aware Resident #203 had any dental pain until recently. Medical Doctor #3 stated Dental Consult recommendations were reviewed but they do not recall reviewing Resident #203's Dental Consult recommending tooth extraction due to pain from a broken tooth. 10 NYCRR 415.17(b)

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 44842 Based on record review and interviews conducted during the Recertification survey from 4/7/2024 through 4/12/2024, the facility did not ensure the Binding Arbitration Agreement granted the resident or representative the right to rescind the agreement within 30 calendar days of signing it. This was evident for 1 (Resident #156) of 38 total sampled residents. Specifically, the Binding Arbitration Agreement signed by Resident #156 did not grant the resident 30 calendar days to rescind the agreement. The findings are: The facility's sample Admission Agreement contained a Binding Arbitration Agreement that documented the agreement can be rescinded within 10 days of the resident's admission to the facility. Resident #156 signed a Binding Arbitration Agreement on 12/22/2021. There was no documented evidence Resident #156 was provided 30 calendar days to rescind the agreement. On 4/12/2024 at 12:51 PM, the Director of Social Service was interviewed and stated they were unaware that the resident or their representative should have the right to rescind the agreement within 30 days of signing it. The facility Binding Arbitration Agreement documents that it may be rescinded within 10 days from the date of the resident's admission to the facility. On 4/12/2024 at 1:10 PM, the Administrator was interviewed and stated the facility Binding Arbitration Agreement states it can be rescinded within 10 days of a resident's admission to the facility. The Administrator stated they were unaware residents had the right to rescind within 30 days of signing the agreement. 10 NYCRR 415.30