| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335506 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bronx Center for Rehabilitation & Health Care | 1010 Underhill Ave<br>Bronx, NY 10472 |

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) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey, the facility did not ensure residents receive treatment and care in accordance with professional standards of practice, and comprehensive person-centered care plan. This was evident for one (1) of five (5) residents reviewed for Unnecessary Medications (Resident #4), out of a sample of 37 residents investigated. Specifically, Resident #4 had a physician's order to notify the physician when Resident's finger stick blood sugar (method of drawing drops of blood from the finger for testing the blood glucose level) result is less than 80 milligrams per deciliter or more than 300 milligrams per deciliter. Licensed Practical Nurse #3 failed to notify the physician when Resident #4's finger stick blood sugar was higher than 300 milligrams per deciliter on 12/02/2025, 12/11/2025, 12/12/2025, and 12/13/2025.The findings include: The facility's policy titled Diabetes Mellitus, Management with a creation date of 07/15/2025 documented the facility provides individualized diabetes management for residents with diabetes mellitus in accordance with Federal/State regulations and current standards of practice, and resident-centered care principles.Resident #4 had diagnoses of Type 2 Diabetes Mellitus, Peripheral Vascular Disease, and Wound Infection.The admission Minimum Data Set assessment dated [DATE] documented that Resident #4 had intact cognition.A Comprehensive Care Plan for Diabetes was initiated on 09/30/2025. The facility interventions include to monitor blood glucose finger stick as per physician orders and monitor for effectiveness of medications given.A physician's order dated 09/29/2025 documented to monitor blood glucose three times a day before meals and to notify the physician if fasting blood sugar results are below 80 milligrams per deciliter and above 300 milligrams per deciliter.The electronic Medication Administration Records for 12/2025 documented the following finger stick blood sugar results: On 12/02/2025 at 7:30 AM, 383 milligrams per deciliter.On 12/11/2025 at 7:30 AM, 360 milligrams per deciliter.On 12/12/2025 at 7:30 AM, 396 milligrams per deciliter.On 12/13/2025 at 7:30 AM, 341 milligrams per deciliter.A review of the nurses' and medical progress notes from 12/02/2025 through 12/13/2025 showed no documentation that the physician was notified when Resident #4's finger stick blood sugar results were above 300 milligrams per deciliter.On 12/19/2025 at 1:31 PM, Licensed Practical Nurse #3 was interviewed and stated they should have notified the nursing supervisor immediately when Resident #4's blood sugar result was over 300 milligrams per deciliter so the supervisor could have notified the doctor. Licensed Practical Nurse #3 stated they were busy and by the time they remembered the nursing supervisor had left for the day.On 12/22/2025 at 2:16 PM, Registered Nurse #4 who was the supervisor was interviewed and stated they were not notified of any high blood sugar results for Resident #4 this month. Registered Nurse #4 also stated Licensed Practical Nurse #3 should have notified them when Resident #4's blood sugar results were above 300 so they can notify the doctor for further instructions.On 12/19/2025 at 1:48 PM, the Medical Director was interviewed and stated they were not notified anytime this month when Resident #4's finger stick blood sugar results were above 300 and they should have been notified as ordered. The Medical Director also stated typical triggers for high blood sugar are infections and noncompliance with diet.On 12/22/2025 at 1:00 PM, the Director of Nursing was interviewed and stated the nurses received in-services back in September 2025 which covered<br>(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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | notifying their supervisors and physicians of high blood sugar results. The nursing supervisors are responsible for calling the doctors for follow up instructions.10 NYCRR 415.12 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that drugs and biologicals were stored in accordance with professional standards. This was evident for two (2) (4th and 5th Floor) of five (5) units observed during medication administration. Specifically, 1.) An expired one (1) liter bag of dextrose intravenous solution and an open undated bottle of liquid hydromorphone was found in the 4th Floor medication storage room. 2.) The 5th Floor medication cart contained expired arginine powder. 3.) The 4th Floor medication cart contained multiple open and undated eye drops and liquid medications.The findings include:The facility policy titled Medication Storage, revised [DATE], documented the facility will store medications safely and securely and in a manner that maintains the integrity of the product in accordance with manufacturer's recommendations, current standards of practice and federal and state regulations. Expired, discontinued and or contaminated medications will be removed from the medication storage areas and disposed in accordance with state and federal regulations.The facility policy titled Multidose Vials, effective [DATE], documented if a multi-dose vial has been opened or accessed the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter) date for that opened vial.On [DATE] at 9:40 AM, during medication administration observation, Licensed Practical Nurse #4 was observed at the medication cart on the Fifth Floor Unit. Prior to medication administration to Resident #92, one (1) box of Arginine Powder containing (10 - 0.32 ounce) individual packets of the supplement was observed stored on the cart and had an expiration date of [DATE]. On [DATE] at 9:45 AM, Licensed Practical Nurse #4 was interviewed and stated all nurses should be checking the expiration dates of the medications and supplements that are stored on the cart and prior to administration and if supplements are expired, they should be discarded immediately.On [DATE] at 11:17 AM, during medication administration and storage observation with Licensed Practical Nurse #5, the Fourth Floor Medication Cart was observed to contain multiple open undated [NAME] dose medications prescribed to the residents including: Sertraline 20 milligrams per milliliter liquid prescribed for Resident #23, Iron 220 milligrams per 5 milliliters prescribed for Resident #6, Lactulose 10grams per 15 milliliter prescribed for Resident #193, Ergocalciferol 100 micrograms per milliliter prescribed for Resident #57. Systane Ophthalmic Solution, Latanoprost Ophthalmic Solution and Dorzolamide Ophthalmic HCl Solution prescribed for resident #190. An 887-milliliter bottle of Pro-Stat Liquid Protein Supplement was observed to have an expiration date of [DATE].On [DATE] at 11:46 AM, During medication storage observation with Licensed Practical Nurse #5, the Fourth Floor Medication Storage Room was observed to contain: (1) One Liter intravenous solution bag of Dextrose (5%) Five Percent with expiration date of 08/2025. (1) One open undated bottle of liquid Hydromorphone (1) One milligram per Milliliter prescribed for Resident #22.On [DATE] at 12:05, an interview was conducted with Licensed Practical Nurse #5 who stated all opened multi-dose medications prescribed should be dated with the date the medication was opened by the nurse who first administered the medication. Licensed Practical Nurse #5 also stated that the intravenous bag bags are not to be left in the medication storage room, they are kept in the nurse's office to be taken to the floor only when needed for administration. Licensed Practical Nurse #5 further stated that the nursing supervisors and managers check the medication storage room and medication administration carts to ensure that the medications are dated and not expired. Both nurses who count the controlled medications at change of shift should have noticed that the Hydromorphone was not dated when opened.On [DATE] at 2:39 PM, an interview was conducted with Registered Nurse #1, The Unit Manager, who stated stored medications should not be expired. The nurses should check for the expiration date of the medication or supplement prior to administration each and every time. Registered Nurse #1 also stated that the nursing supervisors follow up and<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | check the medication administration carts and storage rooms daily and at a minimum weekly and document their findings on an audit sheet. Registered Nurse #1 further stated that the audits include expiration dates of medications, medication reorder dates, they ensure Inhalers, eye drops, and liquid medications are stored in separate bags on the medication administration carts and labeled with the first date used or opened and discarded after 28-30 days or the manufacture's recommendation date. Intravenous administration bags are stored in the nursing office on the first floor and are only to be kept on the floor if actively being administered. A Medication Storage Audit Form dated [DATE] was provided and documented compliance in all areas.On [DATE] at 2:56 PM, an interview was performed with the Director of Nursing who stated that no expired meds should be stored on the medication administration carts. Every time the medication administration cart is used, medication expiration dates should be checked. The nurse should date all eye drops, inhalers and liquid medications prescribed to the resident with the open date, the nurse who first breaks the seal should date and initial these meds. Intravenous medication bags are kept in the nursing office not in the storage room. The bags are taken to the floor only when needed and the expiration dates are checked before use. The Director of Nursing also stated that audits of the medication administration cart, and storage rooms are performed weekly by unit managers, and the findings are documented on an audit tool. The Director of Nursing further stated that they review the audit sheets from the managers and have not seen any documented issues of expired or unlabeled, undated medications. 10 NYCRR 415.18(e)(1-4) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, record review, and interviews, the facility failed to ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, 1.) Infection prevention and control practices were not maintained during residents' meal service. This was evident for one (1) of five (5) units observed during dining. 2.) The resident's clean laundry was observed hanging in a cart without a cover in the lobby and on the 3rd Floor unit. The findings include: 1. The facility policy and procedure titled Use of Gloves - Food Service dated 04/2017, last revised 04/2021 documented that vinyl or latex gloves will be worn when handling foods that will not be further cooked to ensure microorganisms are not transferred from food handler's hands to the food product served. Anytime a gloved hand touches a contaminated surface, the glove must be changed. On 12/15/2025 at 12:28 PM, Dietary Aide #1 was observed using gloved hand to pick up a cover that fell on the floor during meal service and continued to use the same gloved hand to serve residents' food. Dietary Aide #1 was advised by the Surveyor on the need to change their gloves, to wash their hands and put on clean gloves. Dietary Aide #1 was reluctant and continued to use the same glove to serve residents' food.On 12/15/2025 at 12:48 PM, Dietary Aide #1 was interviewed and was asked why they did not change their gloves after picking up a dirty item from the floor. The Dietary Aide stated it was because the box of gloves they keep at the back of the serving area was taken downstairs. On 12/18/2025 at 2:12 PM, the Food Service Director was interviewed and stated that Dietary Aide #1 should know that dirty gloves must be changed, and that they must wash their hands and put on new gloves before continuing to serve food to the residents. 2. The undated facility policy and procedure titled Handling of Personal Laundry documented that to prevent the development and transmission of disease and infection, the laundry will be delivered to the resident's room in a clean, covered laundry cart, and placed in the resident's closet or dresser. Laundry staff will keep closets and dressers neat and organized upon delivery of clean laundry. On 12/16/2025 at 8:20 AM, residents' washed clothes were observed uncovered, hanging on a cart in the lobby. Draft and cold air was blowing on the clothes as staff and visitors enter and exit through the sliding door. On 12/16/2025 at 8:35 AM, Housekeeping Staff #1 was interviewed and stated that residents' clothes were just delivered to the facility by an outside vendor, and they are taking the carts to the units one after the other. Housekeeping Staff #1 stated that the cover was removed after delivery of the clothes to the facility gate. Housekeeping staff #1 further stated that they will cover the clothes before taking them to the unit for distribution. On 12/16/2025 at 9:27 AM, residents' clean clothes / clean laundry were observed uncovered, hanging on the cart in the hallway near the staircase on the 3rd Floor. Registered Nurse #1, who was the unit manager was interviewed and stated that the residents' clean clothes were brought to the unit by Housekeeping Staff #1 without cover. On 12/16/2025 at 9:39 AM, Housekeeping Staff #1 was interviewed and stated they just delivered the residents' clean clothes to the 3rd Floor and went to get the rest of the clothes for other residents on the remaining units. Housekeeping Staff #1 was unable to explain why the residents' clothes were left uncovered on the cart. On 12/19/2025 at 9:17 AM, residents' clean clothes were observed on the 3rd Floor hallway near the staircase, hanging on the cart uncovered. Registered Nurse #1 was interviewed stated that the clean laundry was brought to the unit by the Housekeeping Department earlier in the morning to be distributed to residents' closets. On 12/19/2025 at 9:46 AM, Housekeeping Staff #2 was interviewed and stated that the cart was delivered to the unit earlier in the morning at about 8:00 AM without a cover because the cover was wet and was removed outside prior to taking the cart to the unit. On 12/19/2025 at 9:48 AM, The Director of Maintenance and Housekeeping was interviewed and stated that residents' clean clothes are delivered on Tuesdays and Fridays. They stated that the clean clothes are always covered when delivered and must remain covered when distributing them to the residents' rooms by the housekeeping staff. On 12/22/2025 at 9:23 AM, the Director of Nursing was<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | interviewed and stated they have a contractor who does the residents' laundry. The dirty laundry is picked up on Mondays and Thursdays and clean laundry is delivered on Tuesdays and Fridays. The Director of Nursing stated that residents' clothes must be covered until they are placed in residents' closets. 10 NYCRR415.19 (b)(4)10 NYCRR 415.19 (c) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain an effective pest control program so that the facility is free of pests and rodents. This was evident on the 4th Floor dining room. Specifically, a live cockroach was sighted crawling on the pantry counter near the ice machine where food and beverages were placed during lunch. In addition, the facility's pest control service record documented numerous cockroach sightings on the 4th Floor Unit.The findings include but are not limited to:The Facility Policy titled Pest Control dated 11/2022 documented that the facility shall maintain an ongoing effective pest control program to ensure the building is kept free of pests and rodents. Pest control services are provided through contract with an approved pest control provider. Pest control service visit documentation will be kept on file in the facility.On 12/15/2025 at 11:55 AM, during lunch dining observation a medium sized (1/2 inch) one half inch live cockroach was observed crawling on the [NAME] counter in the dining room under the ice machine and where sandwiches, fruit and cold desserts were placed. The dietary staff was plating food from a steam table. The certified nursing assistants and nurses were serving plates of food to the seated residents. Certified Nursing Assistant #6 was observed to have killed the cockroach with a paper towel. The cockroach sighting was not documented on the consumer sighting report.A review of the 4th Floor Consumer Sighting Report and Pest Control Service Record documented the following pest sightings were reported and treated on: 12/04/2025 - roaches 420B, 12/2/2025 and 11/20/2025 - roaches crawling on the walls and floors in rooms and bathrooms in the late evening, 11/13/2025 x 2 - mice and roaches on the entire unit, 11/04/2025 - lots of roaches in the bathrooms, 11/11/2024 - lots of roaches in the bathrooms, 10/06/2025, 10/14/2025, 10/21/2025, 10/28/2025 - mice in room [ROOM NUMBER], 10/05/2025 - roaches in the nightstand drawer in room [ROOM NUMBER]B.A Pest Management Inspection Report dated 11/25/2025, documented roach complaint on the 2nd Floor unit, room [ROOM NUMBER]. Inspection - positive. Several live roaches observed under the side bottom of the garbage can and in the hinge side of the door jam.A Pest Management Inspection Report dated 12/09/2025, documented roach complaint 4th Floor unit, room [ROOM NUMBER]. Inspection - positive. Live roaches observed in the bathroom door jam at floor hinge side.On 12/22/2025 at 10:00 AM, an observation of the 4th Floor Dining Room and Pantry was performed with the Director of Housekeeping and Maintenance. The pantry counter where the cockroach was previously sighted was observed with damp paper towels beneath the legs of the ice machine. The cabinet beneath the pantry counter was observed with a black dirt smudged floor. The flooring was half torn and covered with a wet towel. Roach traps were observed on the dirty wet floor. The Director of Housekeeping and Maintenance stated that the ice machine filter was changed on Friday 12/09/2025 so under the cabinet was wet and dirty but should have been cleaned up the day of the service especially being that roaches had been sighted there. The Director of Housekeeping and Maintenance further stated that the housekeeper who was assigned on Friday is on vacation.On 12/22/2025 at 10:06 AM, an interview was conducted with Certified Nursing Assistant #6 who stated that they see roaches at least weekly in the dining area. The staff reports the sighting to housekeeping and logs the details in the consumer sighting logbook. Certified Nursing Assistant #6 also stated the 4th Floor unit is serviced by the exterminator weekly.On 12/22/2025 at 8:56 AM, an interview was conducted with the Director of Housekeeper and Maintenance who stated that they were told about the cockroach sighting in the 4th Floor dining room and that everyone staffed on the floor is responsible to keep that area clean though the housekeeper is ultimately responsible. The Director of Housekeeper and Maintenance also stated they have seen roaches in the dining rooms one or two approximately once every 2 months and they normally call the exterminator who will come and perform an extra visit outside of every Tuesday extermination. The exterminator checks the floor logs for sightings and are also directed to additional area of concern. The exterminating company signing off in the logbook is<br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the proof that the area was serviced, and a report weekly is provided after the service and findings. The weekly service includes areas of concern and the entire unit including the dining area. The exterminator places gel and glue traps in the pantry cabinet. The Director of Housekeeper and Maintenance further stated that the logbook does not document the roach sighting on 12/15/2025 though the sighting was reported by a Certified Nursing Assistant who should have documented the incident in the book.10 NYCRR 415.29(j)(5) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 (two) hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for 1 (one) (Resident #11) of 2 (two) residents reviewed for abuse out of 37 total sampled residents. Specifically, on 10/20/2025, Resident #11 alleged that Certified Nursing Assistant #2 told them I heard you like to have your balls rubbed. Resident #11 felt that this was inappropriate. The alleged incident was not reported to the New York State Department of Health. The findings are:The facility's policy titled Abuse which was last revised on 07/18/2025 documented that the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. Allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by the facility management. The reporting protocol documents that it is the facility's policy to notify local law enforcement and appropriate State Agency(s) immediately (no later than 2 (two) hours after allegation/identification of allegation) by the Agency's designated process after identification of alleged/suspected incident.Resident #11 had diagnoses which included Cerebral Infarction and Diabetes Mellitus.The quarterly Minimum Data Set assessment dated [DATE] documented that Resident #11 had moderate cognitive impairments. It also documented that Resident #11 did not experience hallucinations or delusions, and did not exhibit physical or verbal behaviors, or rejection of care during the assessment period.The Comprehensive Care Plan initiated on 07/12/2023 documented Resident #11 was at risk for misappropriation, neglect, abuse, and/or exploitation related to their dependence on others for care.A Grievance Form dated 10/20/2025 documented that Resident #11's family member contacted the Social Worker and informed them that on 10/19/2025, the aide, whose name was not known, went to the resident's room to change their incontinence briefs. The aide allegedly told Resident #11 I heard you like to have your balls rubbed. The grievance form documented that the Director of Nursing spoke with Certified Nursing Assistant #2 who stated they only used the word balls because the resident used it. The form documented that Certified Nursing Assistant #2 was apologetic and that it appeared to be a case of poor judgment on Certified Nursing Assistant #2's part. The grievance investigation concluded there was no evidence of abuse and neglect and that the Department of Health was not notified. Certified Nursing Assistant #2 was removed from employment at the facility. The Accident/Incident Statement Form completed by Certified Nursing Assistant #3 documented that Resident #11 informed them that Certified Nursing Assistant #2 asked if Resident #11 wanted their balls to be massaged.On 12/16/2025 at 11:47 AM, Resident #11 was interviewed and stated that Certified Nursing Assistant #2 was providing incontinence care to Resident #11 on the evening shift on 10/18/2025 when Certified Nursing Assistant #2 stated Oh, I hear you like to have your balls rubbed. Resident #11 stated that they informed their family member who then notified the facility, and Resident #11 also notified Certified Nursing Assistant #3 who worked the morning shift on 10/20/2025. Resident #11 stated that they felt that Certified Nursing Assistant #2's comment was inappropriate.On 12/19/2025 at 11:30 AM, Social Worker #2 was interviewed and stated that on 10/20/2025, Resident #11's family member called them and reported that a Certified Nursing Assistant asked Resident #11 if they wanted their balls rubbed. Social Worker #2 stated that they immediately called the Director of Nursing so that the Director of Nursing could begin an investigation. Social Worker #2 stated that the Director of Nursing is responsible for investigating abuse allegations<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and reporting them to the proper authorities.On 12/18/2025 at 10:19 AM, the Director of Nursing was interviewed and stated that they are responsible for investigating and reporting allegations of abuse. Social Worker #2 received the initial report from Resident #11's family member. The Director of Nursing stated that the report they received from Social Worker #2 stated that Certified Nursing Assistant #2 had used the word balls while providing care to Resident #11. The Director of Nursing stated they were not aware that Resident #11 alleged that Certified Nursing Assistant #2 asked the resident if they wanted their testicles to be rubbed or massaged. The Director of Nursing stated that because they believed the concern was related to unprofessional language, they did not treat the allegation as a potential abuse allegation and therefore, did not report it to the New York State Department of Health. 10 NYCRR 415.4(b) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335506 | A. Building<br>B. Wing | 12/22/2025 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure that all alleged violations involving abuse were thoroughly investigated. This was evident for 1 (one) (Resident #11) of two (2) residents reviewed for abuse out of 37 total sampled residents. Specifically, on 10/20/2025, Resident #11's family member alleged that on 10/19/2025, Certified Nursing Assistant #2 allegedly made an inappropriate remark towards Resident #11 that offended the resident. The facility initiated the investigation but did not thoroughly investigate the allegation. The facility failed to interview other staff on the unit who may have potentially witnessed the alleged incident. Cross Reference F-tag 609 The findings are:The facility's policy titled Abuse last revised 07/18/2025 documented that the facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. Allegations/reports of suspected abuse, neglect, mistreatment, distortion, injury of unknown etiology or misappropriation shall be promptly and thoroughly investigated by facility management. Upon receiving an incident or suspected incident of resident abuse, neglect, misappropriation of resident property, or injury of an unknown source, the Administrator/Director of Nursing/designee will conduct an investigation to include but not limited to: complete designated report form for investigation of abuse, neglect, misappropriation; interview the person reporting the incident; interview any witnesses to the incident; interview the resident; interview the resident's attending physician and review the resident's record; interview staff members on all shifts having contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents to which the accused employee provides care or services; review all circumstances surrounding the incident. The Administrator/Director of Nursing is responsible to receive and investigate all alleged violations in a timely objective manner. The Administrator/ DON should analyze the report and consult with other resources such as the Medical Director to investigate medical circumstances, or the social worker, as appropriate.Resident #11 had diagnoses including Cerebral Infarction and Diabetes Mellitus.The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #11 had moderate cognitive impairments. It also documented that Resident #11 did not experience hallucinations or delusions, and did not exhibit physical or verbal behaviors, or rejection of care during the assessment period.The Comprehensive Care Plan initiated 07/12/2023 documented Resident #11 was at risk for misappropriation, neglect, abuse, and/or exploitation related to their dependence on others for care.A Grievance Form dated 10/20/2025 documented that Resident #11's family member contacted the Social Worker and informed them that on 10/19/2025, the aide, whose name was not known, went to the resident's room to change their incontinence briefs. The aide allegedly told Resident #11 I heard you like to have your balls rubbed. The grievance form documented that the Director of Nursing spoke with Certified Nursing Assistant #2 who stated they only used the word balls because the resident used it. The form documented that Certified Nursing Assistant #2 was apologetic and that it appeared to be a case of poor judgment on Certified Nursing Assistant #2's part. The grievance investigation concluded there was no evidence of abuse and neglect and that the Department of Health was not notified. Certified Nursing Assistant #2 was removed from employment at the facility. A written statement dated 10/22/2025 by Certified Nursing Assistant #2, who was the accused, documented that Resident #11 was in their assignment on the evening shift of 10/18/2025 and that they cleaned the resident about four (4) times that shift. The Certified Nursing Assistant documented that the resident told them to wash my balls again which she did and after that the resident told them to hand them the washcloth so they could do it themselves. Certified Nursing Assistant #2 stated they never had inappropriate conversation with Resident #11 and had not disrespected the resident. There was no documented evidence that other staff members who had contact with Resident #11, who may have potentially<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | witnessed the alleged incident, were interviewed or provided statements regarding the allegation. On 12/16/2025 at 11:47 AM, Resident #11 was interviewed and stated that Certified Nursing Assistant #2 was providing incontinence care to Resident #11 on the 10/18/2025 evening shift when Certified Nursing Assistant #2 stated Oh, I hear you like to have your balls rubbed. Resident #11 stated that they informed their family member who then notified the facility, and Resident #11 also notified Certified Nursing Assistant #3 who worked the morning shift on 10/20/2025. Resident #11 stated they felt that Certified Nursing Assistant #2's comment was inappropriate.On 12/18/2025 at 11:28 AM, Certified Nursing Assistant #3 was interviewed and stated that at an unknown time during the 7:00 AM to 3:00 PM shift on 10/20/2025, Resident #11 told them that Certified Nursing Assistant #2 , who worked the evening shift, had asked Resident #11 if they wanted their balls to be massaged. On 12/19/2025 at 11:30 AM, Social Worker #2 was interviewed and stated that on 10/20/2025, Resident #11's family member called them and reported that a Certified Nursing Assistant asked Resident #11 if they wanted their balls rubbed. Social Worker #2 stated that they immediately called the Director of Nursing so that the Director of Nursing could begin an investigation. Social Worker #2 stated that the Director of Nursing is responsible for investigating abuse allegations and reporting them to the proper authorities.On 12/18/2025 at 10:19 AM, the Director of Nursing was interviewed and stated that they are responsible for investigating and reporting allegations of abuse. Social Worker #2 received the initial report from Resident #11's family member. The Director of Nursing stated that the report they received from Social Worker #2 stated that Certified Nursing Assistant #2 had used the word balls while providing care to Resident #11. They stated they were not aware that Resident #11 alleged that Certified Nursing Assistant #2 asked the resident if they wanted their testicles to be rubbed or massaged. The Director of Nursing stated that because they believed the concern was related to unprofessional language, they did not treat the allegation as a potential abuse allegation. The Director of Nursing was unable to provide an explanation for why they did not interview other staff members on the unit following the allegation.10 NYCRR 415.4(b)(3) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**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 with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. This was evident for one (1) (Resident #9) of two (2) residents reviewed for position and mobility out of 35 total sampled residents. Specifically, Resident #9 who had a right-hand contracture, was not provided with a right palm guard as per rehabilitation recommendations.The findings are:The facility policy titled Adaptive Equipment with a revised date of 01/20/2025 documented the Rehabilitation Department will recommend safe and appropriate adaptive equipment used to enhance Activities of daily living, safety, quality of life and independence. The facility will provide adaptive equipment and appropriate assistance to assure that the resident can use the adaptive device properly. Recommendations to the resident's care plan and Certified Nursing Assistance Kardex should be provided as indicated with the necessary adaptive equipment and parameters for its use.The facility policy and procedure titled Therapy Referral and Communication with a revised date of 07/30/3025 documented the facility utilizes an interdisciplinary team collaborative process to communicate a potential and or actual resident need for rehabilitation therapy services and to receive communication from rehabilitation services regarding resident needs in accordance with Federal and State Regulations and current standards of practice. The Rehabilitation Recommendation and Communication User defined Assessment Form will be utilized to communicate and document in the clinical record the therapy referral recommendations. The recommendations may include but are not limited to adaptive and assistance devices, adaptive feeding equipment, communication devices, mobility devices, restorative nursing program, and splints, prosthetics and orthotics.Resident #9 was admitted to the facility with diagnoses that included Cerebrovascular accident and Hemiplegia.The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #9 had intact cognition, and impaired mobility with functional limitation in range of motion on one side of their upper and lower extremities.On 12/15/2025 at 11:20 AM, Resident #9 was observed with an unsupported contracted right hand. No device was observed on the contracted extremity.Resident #9 was interviewed and stated that they could not recall having a device applied to their hand or arm in 2025.On 12/17/2025 at 10:17 AM, Resident #9 was observed in bed. The resident's right hand was observed contracted without a device.The Rehabilitation Recommendation and Communication User-defined Assessment Form dated 10/03/2025 documented that Resident #9 was placed in skilled therapy for contracture management. A right palm guard was provided to replace the right-hand resting splint.An Occupational Therapy Discharge Summary with dates of service 10/03/2025 to 10/29/2025, documented discharge recommendations: Right palm guard to be used at all times except for skin checks, activities of daily living and hygiene.A Care Plan Activity Report reviewed 12/03/2025, documented that Resident #9 had a musculoskeletal flexion impairment to the right upper extremity for which a right palm guard should be applied during the day.On 12/18/2025 at 3:40 PM, an interview was conducted with the Rehabilitation Director who stated that an occupation therapy recommendation for Resident #9 was provided to the nursing staff for discharge recommendations on 10/29/2025 that included the application of a right palm guard to be used at all times.On 12/18/2025 at 4:13 PM, an interview was conducted with Occupational Therapist #1 who stated that Resident #9 was initially wearing a resting splint to the right hand that was to be removed only for hygiene and skin checks. The resident's hand was painful, and they would ask the staff to remove the hand roll. The Occupational therapist further stated that after therapy reassessment in October, they communicated with the Interdisciplinary team the recommendation for a palm guard to be always applied to the right hand except for skincare, activities of daily living and hygiene. On 12/22/2025 at 2:24 PM, an interviewed was conducted with Registered Nurse #1, who was the nurse manager for<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Unit 4, who stated that the process for receiving rehabilitation recommendations includes receiving a written communication form the therapists, Recommendations can include splints and other devices. The nurse manager updates the electronic chart with the order and care plan, and a copy is placed in the resident's record.On 12/22/2025 at 10:53 AM, an interview was performed with the Director of Nursing who stated that they reviewed Resident #9's clinical record and found that the therapy recommendation for application of a right palm guard was not picked up and entered into the electronic medical record by nursing. Therefore, the application of the right-hand palm guard was not placed as a Kardex task for the certified nursing assistant to perform and they did not perform the task. The Director of Nursing also stated that the nurse manager on the unit is responsible to review the paper rehabilitation recommendations that is placed in the manager's mailbox and enter the recommendations into the electronic medical record, they also receive a copy but do not recall receiving these recommendations for Resident #9, as they would have followed up. The Director of Nursing further stated that the rehabilitation recommendation form for Resident #9 is signed by nursing, but they cannot read the signature. 10 NYCCR 415.12 (e) (2) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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 necessary respiratory care in accordance with professional standards of practice. This was evident for one (1) (Resident #159) of one (1) resident reviewed for respiratory care out of 37 total sampled residents. Specifically, Resident #159 was observed receiving oxygen via nasal cannula without a physician's order. The findings are:The facility policy titled Oxygen Therapy Administration revised 09/17/2025 documented oxygen therapy is administered by licensed nurses or respiratory therapists in accordance with healthcare provider orders and in accordance with the state scope of practice and nurse practice act.Resident #159 had diagnoses of Diabetes Mellitus and Influenza.The admission Minimum Data Set assessment dated [DATE] documented Resident #159 had severely impaired cognition and received oxygen therapy.On 12/17/2025 at 10:37 AM and 12/18/2025 at 9:58 AM, Resident #159 was observed with Oxygen in use at 2.5 liters per minute via nasal canula. A Comprehensive Care Plan for at risk/has an alteration in respiratory system, oxygen use was initiated on 12/01/2025. The facility interventions included observing for signs of poor airway clearance and observing vital signs and report those that are not within normal limits to the physician. A medical history and physical completed by the Medical Director dated 12/02/2025 documented that Resident #159 was treated in the hospital for Influenza A infection. The resident was treated conservatively with guaifenesin 100 milligram every 6 hours as needed and oxygen that they have been weaning off.Review of the nurses' progress notes from 12/04/2025 through 12/16/2025 documented that Resident #159 was on oxygen via nasal cannula. A physical medicine and rehabilitation evaluation note dated 12/12/2025 documented that Influenza, an acute condition, has been resolved, and to continue oxygen via nasal cannula as needed. The interdisciplinary meeting progress notes dated 12/18/2025 documented that the meeting was attended by nursing, social services, rehabilitation therapy, and the resident's representative via phone call. The note documented that according to nursing, Resident #159 was being weaned off oxygen.A review of the physician's order for 12/2025 revealed no attending practitioner's orders and indication for oxygen use.On 12/19/2025 at 11:03 AM, Licensed Practical Nurse #2 was interviewed and stated Resident #159 receives oxygen through a concentrator when in their room. After reviewing Resident #159's medical record, Licensed Practical Nurse #2 stated, That's weird when Resident #159 was admitted they had an oxygen order. Licensed Practical Nurse #2 was unable to provide an explanation for oxygen use without a medical doctor's order and for how the flow rate of 2.5 liters per minute was determined.On 12/22/2025 at 11:08 AM, Registered Nurse #3 was interviewed and stated Resident #159 does not need oxygen during the day, but requests to use oxygen at night. Registered Nurse #3 also stated there should be an order when oxygen is used, and it is their fault that there was no order.On 12/19/2025 at 2:09 PM, the Medical Director was interviewed and stated when they visited Resident #159 after admission, they were not using oxygen and not complaining of shortness of breath. The Medical Director also stated they have not received any hypoxic (low level of oxygen) reports regarding Resident #159, but they heard Resident #159 requested oxygen.On 12/22/2025 at 12:50 PM, the Director of Nursing was interviewed and stated Resident #159's Patient Review Instrument did not document the need for oxygen and Resident #159's oxygen saturation rate had not fallen below 95% since admission. They stated it is possible Resident #159 felt that they needed oxygen, however, the doctor would be called for an order and then a care plan would be implemented.10 NYCRR 415.12(k)(6) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure that a physician reviewed the resident's total program of care, including treatments at each visit. This was evident for one (1) (Resident #159) of one (1) resident reviewed for respiratory care out of 37 total sampled residents. Specifically, Resident #159 was observed receiving oxygen via nasal cannula. A review of interdisciplinary progress notes revealed that Resident #159 was receiving oxygen via nasal cannula, however, there was no attending practitioner's orders and indication for oxygen use.Cross refer to F-tag 695 The findings are:The facility policy titled Oxygen Therapy Administration revised 09/17/2025 documented oxygen therapy is administered by licensed nurses or respiratory therapists in accordance with healthcare provider orders and in accordance with the state scope of practice and nurse practice act.Resident #159 had diagnoses of Diabetes Mellitus and Influenza.The admission Minimum Data Set assessment dated [DATE] documented Resident #159 had severely impaired cognition and received oxygen therapy.On 12/17/2025 at 10:37 AM and 12/18/2025 at 9:58 AM, Resident #159 was observed with Oxygen in use at 2.5 liters per minute via nasal canula. A Comprehensive Care Plan for at risk/has an alteration in respiratory system, oxygen use was initiated on 12/01/2025. The facility interventions included observing for signs of poor airway clearance and observing vital signs and report those that are not within normal limits to the physician. A medical history and physical completed by the Medical Director dated 12/02/2025 documented that Resident #159 was treated in the hospital for Influenza A infection. The resident was treated conservatively with guaifenesin 100 milligram every 6 hours as needed and oxygen that they have been weaning off.Review of the nurses' progress notes from 12/04/2025 through 12/16/2025 documented that Resident #159 was on oxygen via nasal cannula. A physical medicine and rehabilitation evaluation note dated 12/12/2025 documented that Influenza, an acute condition has been resolved, and to continue oxygen via nasal cannula as needed. The interdisciplinary meeting progress notes dated 12/18/2025 documented that the meeting was attended by nursing, social services, rehabilitation therapy, and the resident's representative via phone call. The note documented that according to nursing, Resident #159 was being weaned off oxygen. A review of the physician's order for 12/2025 revealed no attending practitioner's orders and indication for oxygen use.On 12/22/2025 at 11:08 AM, Registered Nurse #3 was interviewed and stated Resident #159 does not need oxygen during the day, but requests to use oxygen at night. Registered Nurse #3 also stated there should be an order when oxygen is used.On 12/19/2025 at 2:09 PM, the Medical Director, who was the attending provider, was interviewed and stated when they visited Resident #159 after admission, they were not using oxygen and not complaining of shortness of breath. The Medical Director also stated they have not received any hypoxic (low level of oxygen) reports regarding Resident #159, but they heard Resident #159 requested oxygen.10 NYCRR 415.15(b)(2)(iii) |

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| F 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation, record review, and interviews conducted during the Recertification Survey from 12/15/2025 to 12/22/2025, the facility did not ensure that the results of the most recent health survey were posted in a place readily accessible to residents, visitors, or legal representatives of residents, where individuals wishing to examine survey results do not have to ask to see them. Specifically, the facility stored a copy of their health survey results on the inner side of the reception desk that required those wishing to examine the results to ask the Receptionist to hand them the results.The findings are:During multiple observations made on 12/15/2025 and 12/16/2025, the health survey results for the Recertification Survey conducted from 07/10/2023 to 07/14/2023 were observed in a binder located on the inner side of the reception desk in a location that required those wishing to examine survey results to ask the Receptionist to hand them the binder.On 12/16/2025 at 10:30 AM, 11 residents of the Resident Council were interviewed and stated that they did not know where to locate the survey results in the facility.On 12/16/2025 at 12:04 PM, the Receptionist was interviewed and stated that the binder containing survey results is typically stored in its current location, which was on the inner side of the reception desk. The Receptionist further stated that if anyone requests to review the survey results, the Receptionist will hand them the binder.On 12/16/2025 at 12:09 PM, the Director of Nursing was interviewed after observing the survey results on the inner side of the reception desk with the Surveyor. The Director of Nursing stated that they are responsible for ensuring the survey results are in the binder and that the binder is accessible to anyone who wishes to view the survey results. The Director of Nursing stated that the survey results are supposed to be stored on the outer side of the desk where those wishing to examine the results do not need to ask the Receptionist to see them. The Director of Nursing further stated that they believed the results were always being stored on the outer side of the desk and was unable to provide an explanation for why it was observed on the inner side of the desk on 12/15/2025 and 12/16/2025. The Director of Nursing stated that there was no facility policy or procedure related to accessibility of survey results.10 NYCRR 415.3(d)(1)(vi) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, record review, and interviews, the facility failed that nurse staffing information was consistently posted in a prominent place readily accessible to residents and visitors. Specifically, staffing information was not consistently posted daily; and the posting of staffing did not indicate the daily resident census. The findings are: The facility policy and procedure titled Staffing-Posting of Hours, Payroll Based Journal dated 10/2014, last revised on 10/2022, documented that the facility will post hours daily in a clear readable format in a prominent place, readily accessible to residents and visitor. Posting should include facility name, current date, and resident census (residents in the facility at midnight). On 12/15/2025 at 9:00 AM, during the Survey entrance, there was no documentation of resident census on nurse staffing information dated 12/15/2025 that was posted at the facility lobby. On 12/22/2025 at 8:36 AM, there was no nurse staffing information posted at the facility lobby or a prominent place readily accessible to residents and visitors. There was no documented evidence of resident census on the nurse staffing information dated from 12/15/2025 to 12/19/2025. On 12/22/2025 at 12:23 PM, the Director of Nursing was interviewed and stated that the Staffing Coordinator is responsible for posting the nurse staffing information every day during weekdays, and the morning shift nursing supervisor is responsible for posting it on weekends. The Director of Nursing further stated that they are not aware that the resident's census was not being documented on the nurse staffing information. 10 NYCRR 415.13 |