STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335581	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Multicare Nursing and Rehab Center	801 CO Op City Blvd Bronx, NY 10475

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 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** Based on observation, record review, and interview during the Recertification and Complaint Survey (Complaint #666294) conducted from 07/28/2025 to 08/04/2025, the facility failed to ensure a resident received adequate supervision and assistance consistent with the resident's needs to prevent accidents. This was evident for one (1) (Resident #49) of seven (7) residents reviewed for accidents out of 35 total sampled residents. Specifically, Resident #49 fell and sustained major injury while being provided care in bed by Certified Nursing Assistant #2. This resulted in actual harm to Resident #49 that was not Immediate Jeopardy.The findings include:The facility policy titled Accidents/Incidents with a last revised date of 12/12/2022 documented Avoidable Accident - Resident had an accident and the facility failed to: 1) Identify environment hazards and individual resident risk for accident, including the need for supervision; 2) Implement interventions, including adequate supervision, consistent with resident's needs, goals and plan of care and recognized standards of practice, to reduce the risk of an accident; 3) Monitor the effectiveness of the interventions and modify the approaches as necessary, in accordance with relevant care standards.Resident #49 had diagnoses of Generalized Muscle Weakness, Alzheimer's Disease (a type of dementia that affects memory, thinking and behavior.), and Cerebrovascular Accident (interruption in the flow of blood to cells in the brain). The Minimum Data Set (a resident assessment tool) dated 10/30/2024 documented Resident #49 had impaired memory, severely impaired cognitive skills, and had impairment on both sides of both upper and lower extremities. The assessment documented Resident #49 was dependent on staff (resident does none of the effort to complete the activity, staff does all the effort or requires the assistance of two (2) or more staff to complete the activity) for activities of daily living including upper and lower body dressing and rolling left and right. A comprehensive care plan for functional abilities was initiated on 11/20/2023. The care plan documented Resident #49 had self-care limitations and was dependent on staff for upper and lower body dressing. The care plan did not indicate the number of staff assistance required. The care plan was reviewed on 11/20/2024; the care plan notes documented by Minimum Data Set Assessor #1 stated plan of care was still applicable. A comprehensive care plan for mobility limitations was initiated on 07/29/2024. The care plan documented Resident #49 required substantial/maximal assistance (staff lifts or holds trunks or limbs and provides more than half the effort) for bed mobility or rolling left to right. The care plan did not indicate the number of staff assistance required. The care plan was reviewed on 11/20/2024; the care plan notes documented by Minimum Data Set Assessor #1 stated Resident #49 was non-ambulatory and required a mechanical lift for transfers. The Resident Nursing Instruction Form (contains instructions for Certified Nursing Assistants) documented on 01/11/2023, Resident #49 was totally dependent for bed mobility and required two (2) person physical assist; and was totally dependent for upper and lower body dressing and required one (1) person physical assist. The nursing instruction also documented Resident #49 was confused, at high risk for falls, and had left-sided weakness and left foot tremors. There was no documented evidence the comprehensive care plan nor the Resident Nursing Instruction Form was updated to include the Minimum Data Set assessment dated [DATE], indicating the resident was (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 0689 Level of Harm - Actual harm Residents Affected - Few	dependent, requiring two (2) or more staff for activities of daily living including upper and lower body dressing and rolling left and right.A plan of care notes by Registered Nurse #2 dated 12/18/2024 documented, Writer responded into a thud in Resident #49's room at 1:30 AM when resident was observed on the floor lying on their right side facing the bed with legs extended. Noted with nose injury and bleeding that appeared to be from the back of the head. As per staff assigned, Certified Nursing Assistant #2 was changing and removing resident's wet gown from feeding when the resident fell on the floor. Unable to fully assess the resident on the extent of injury due to their position on the floor. The resident was transferred to the hospital emergency room. The Nursing's Review of Accident/Incident Form completed by the Risk Manager dated 12/20/2024 documented that on 12/18/2024 at 1:30 AM, a thud was heard in Resident #49's room. The nursing supervisor and the floor nurse responded, and they observed Resident #49 on the floor lying on their right side, facing the bed with legs extended. The right side of the resident's nose was resting against the foot frame of the metal bed. The resident was nonverbal and unable to give an account. On assessment, the resident was noted with a nasal injury and bleeding that appeared to be from the right side of the head. 911 (emergency medical service) was immediately activated. According to Certified Nursing Assistant #2, they were changing the resident's wet gown and as they were removing the gown from the right hand, the resident reached over and began to slide off the bed. The Certified Nursing Assistant tried to pull the resident back to bed but was heavy and they slid off the bed. The facility investigation concluded that Resident #49 made an unpredictable maneuver during care as they reached over while the staff was removing their gown resulting in the resident sliding off the bed; there was no evidence to suggest that abuse or neglect occurred. The hospital Physician Discharge summary dated [DATE] documented Resident #49 was admitted on [DATE] and was discharged back to the nursing home on [DATE]. Resident #49 presented from the nursing home after a fall and was found to have nasal bone fractures (broken bones), right frontal scalp and right premaxillary (bones of the upper jaw) hematomas (areas of pooled blood), and with severe epistaxis (nose bleeding) as seen in the computed tomography scan (imaging test that uses a combination of x-ray and computer technology). The resident had high volume nosebleeds and was transferred to the intensive care unit for monitoring. The bleeding stopped on 12/24/2024 and had been stable since then. Resident #49 was also treated for lower lobe pneumonia (lung infection) while in the hospital. On 08/01/2025 at 8:01 AM, Certified Nursing Assistant #2, who was assigned to Resident #49 on the date and time of incident, was interviewed and stated they have been working in the facility for about a year and had Resident #49 in their assignment when they worked in the unit. They stated Resident #49 required assistance of two (2) staff for bed mobility. They stated on the day of the incident, the nurse asked them to change Resident #49's gown that got messed up with feeding. They stated, as they were changing the gown, the resident's hand swung, and the resident fell on the floor. They stated they were not able to hold the resident because the resident was too heavy. Certified Nursing Assistant #2 stated they thought they could change Resident #49's gown alone because the resident does not require a lot of turning. On 08/01/2025 at 8:13 AM, Registered Nurse #2, who was the nursing supervisor on duty on the day of the incident, was interviewed and stated they were at the nursing station during shift rounds when they heard a sound coming from Resident #49's room. They stated they went into the room and saw the resident on the floor, Certified Nursing Assistant #2 was on the opposite side of the resident's bed. They stated, according to Certified Nursing Assistant #2, they were trying to change the resident's gown when the resident fell off the bed. Registered Nurse #2 stated Resident #49 required one (1) assist for dressing, but based on resident's mobility and weight, the Certified Nursing Assistant should have asked for assistance from a second staff to prevent the resident from falling.On 08/01/2025 at 10:08 AM, Registered Nurse #3, who was the Unit Manager, was interviewed and stated the incident occurred overnight, and from the incident report, Certified Nursing Assistant #2 was trying to do resident care by themself during the night when Resident #49 fell from the bed and sustained injuries. Registered Nurse #3 stated that the fall could have been (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	prevented if Certified Nursing Assistant #2 had another staff to assist them in the care that required moving the resident in bed. Registered Nurse #3 also stated Resident #49 needed total assist of one (1) for dressing but would require assistance of two (2) staff for bed mobility. On 08/04/2025 at 11:23 AM, the Risk Manager was interviewed and stated the investigation revealed Certified Nursing Assistant #2 followed the instructions on the Certified Nursing Accountability Record that documented Resident #49 required one (1) staff assistance for dressing and two (2) staff assistance for bed mobility. They stated Resident #49 moved and rolled out of bed when Certified Nursing Assistant #2 was taking off the resident's gown. On 08/01/2025 at 8:50 AM, Minimum Data Set Assessor #1 was interviewed and stated that based on the input from the staff and rehabilitation department, Resident #49 was assessed to be totally dependent of staff with two (2) staff assistance for bed mobility and dressing. They stated this was reflected on the Certified Nursing Assistant Instructions. The Assessor stated they cannot explain why the resident's bed mobility and dressing was done by only one (1) staff that resulted in fall and injury, because the instruction was clear. On 08/04/2025 at 11:44 AM, the Director of Nursing was interviewed and stated Resident #49 was assessed to be one (1) assist for dressing at the time of the incident, and they thought resident just moved while being dressed causing the resident to fall. The Director of Nursing stated it could have been better and safer if two (2) staff had given the care to the resident at the time.On 08/04/2025 at 11:50 AM, the Administrator was interviewed and stated the incident with Resident #49 occurred before they assumed office. The Administrator stated that if the resident required the assistance of two (2) staff and only one (1) staff was giving the care, there is going to be a problem.10 NYCRR 415.12(h)(2)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/28/2025 to 08/04/2025, the facility failed to ensure that residents who needed respiratory care were provided care that was consistent with professional standards of practice. This was evident for 3 (Residents #27, #451 and #412) of 5 residents reviewed for respiratory care out of 35 total sampled residents. Specifically, 1.) Nebulizer mask, oxygen cannula, and oxygen tubes were observed in residents' bedside that were not dated and were exposed or not kept in a bag. 2.) Resident #412 was observed receiving oxygen without a physician's order.The findings include: The facility's policy titled Oxygen Therapy with a last reviewed date of 07/2018 stated that Oxygen therapy must be ordered by a physician except during emergency when a Registered Nurse may initiate oxygen therapy without a physician's order and then obtain the order by telephone. The policy stated a sealed package with a nasal cannula will be attached to the oxygen tank. Nasal catheters, masks, tubings and cannulas are to be changed every week. 1. Resident #27 was admitted to the facility with diagnoses that included Cerebral Palsy, Chronic Obstructive Pulmonary Disease, and Respiratory Failure. The comprehensive Minimum Data Set assessment dated [DATE] documented that Resident #27 had severely impaired cognition for daily decision making, shortness of breath when lying flat and required oxygen administration on admission and while a resident at the facility. A care plan for oxygen therapy was initiated on 04/04/2025. The facility interventions included to provide oxygen as ordered by the medical doctor. A physician's treatment order dated 04/06/2025 documented oxygen administration via nasal cannula / mask at two (2) to three (3) liters per minute as needed for shortness of breath. During observation on 07/29/2025 at 12:19 PM and on 07/30/2025 at 11:54 AM, an undated and unlabeled nebulizer mask with tubing, and an oxygen concentrator with an undated nasal cannula containing a one half (1/2) bottle of two hundred fifty (250) milliliters sterile water dated 06/15/2025 were observed at Resident #27's bedside. The nebulizer mask and tubing were exposed and not stored in a bag. A review of Resident #27's physician's treatment order revealed no active order for nebulization. An order for Ipratropium and Albuterol solution, three (3) milliliters to be inhaled every six (6) hours for ten (10) days has been discontinued on 04/06/2025. 2. Resident #451 was admitted to the facility with diagnoses that included Cerebral Vascular Accident with Hemiplegia and Orthopnea. The comprehensive Minimum Data Set assessment dated [DATE] documented that Resident #451 had severely impaired cognition for daily decision making and had shortness of breath when lying flat. A physician's treatment order dated 07/27/2025 documented Oxygen administration via nasal cannula or mask two (2) liters per minute as needed for shortness of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 07/29/2025 at 11:48 AM and on 07/30/2025 at 8:45 AM, an undated oxygen nasal cannula connected to and hanging from an oxygen tank was observed at the bedside of Resident # 451. The nasal cannula was exposed and was not kept in a bag. A review of medication and treatment administration record had no documentation as to when the nasal cannula was last changed. On 07/30/2025 at 8:45 AM, Licensed Practical Nurse #4 was interviewed and stated the oxygen tubing should have been changed and dated by night shift nurses. On 07/30/2025 at 8:54 AM, Registered Nurse #8, who was the Nursing Supervisor, was interviewed and stated that the oxygen tubing should have been labeled and dated by the night shift nurses, and all staff should be ensuring that all the tubings are labeled and dated when they are providing care, treatments and medication administration. Registered Nurse #8 stated they missed the undated oxygen tubing when they performed rounds. On 08/04/2025 at 8:17 AM, the Director of Nursing was interviewed and stated that oxygen nasal cannula tubing and masks utilized for nebulizer treatment administration should be dated and changed weekly by the night nurses. The Director of Nursing also stated that the distilled water utilized for the administration of oxygen should have been discarded within 24 hours and the rounding nurse supervisor and possibly the respiratory staff should have observed that the tubing was undated and the oxygen bottle old. The Director of Nursing further stated that the registered nurse supervisors and managers should be performing rounds to ensure that care and maintenance of oxygen tubing and nebulizer treatments are performed and that oxygen tubes are dated. 3. Resident #412 was admitted to the facility with diagnoses that included Alzheimer's Disease, Atrial Fibrillation, and Hyperlipidemia. The Minimum Data Set (a resident assessment tool) dated 06/30/2025 documented that the resident had no respiratory diagnoses, was not short of breath and was not receiving oxygen therapy. On 07/27/2025, Resident #412 was observed using oxygen via nasal canula at 2 liters per minute. The resident was observed using oxygen daily from 07/27/2025 through 08/04/2025. Resident # 412's medical orders were reviewed and contained no orders regarding oxygen delivery, change of canula tubing or pulse oximetry. On 08/01/2025 at 11:48 AM, Licensed Practical Nurse #3 was interviewed and stated that Resident #412 had some shortness of breath recently and is currently using oxygen around the clock. They stated that Resident #412 refuse to remove the oxygen. Licensed Practical Nurse #3 stated they had not seen an order to administer oxygen for Resident #412. On 08/04/2025 at 11:23 AM, Registered Nurse #7, who was the Nurse Manager, was interviewed and stated Resident #412 had infection recently and in that case the nurses automatically start an order for oxygen or get a telephone order from the doctor to administer oxygen. They stated they made a mistake and will fix it. On 08/04/2025 at 2:50 PM, the Director of Nursing was interviewed and stated that Resident #412 should have a care plan for oxygen use. They stated that the physician can enter the order for the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, or they can also give a telephone order to the nurse and the nurses can enter it. On 08/04/2025 at 3:02 PM, Physician #1 was interviewed and stated they last evaluated Resident #412 in July and found the resident was stable and has no need for oxygen. They stated they had treated Resident #412 3 or 4 months ago for a respiratory infection and had ordered oxygen at that time because the resident's oxygen saturation level had decreased to 82-84 percent, but the order was cancelled when Resident #412's respiratory status improved. Physician #1 said they had not been made aware that Resident #412 was receiving oxygen at this time. 10NYCRR415.12(k)(6)

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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** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/28/2025 to 08/04/2025, the facility failed to ensure that all alleged violations involving abuse or neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury to the New York State Department of Health. This was evident for 1 (Resident #318) of 7 residents reviewed for Accidents out of 35 total sampled residents. Specifically, the facility did not report to the New York State Department of Health an unwitnessed incident on 07/10/2025 when Resident #318 was observed on the floor with a laceration to the forehead that required 5 sutures. Resident #318 was unable to explain the occurrence. The findings include:The facility's policy and procedure titled Accidents/Incidents with a last reviewed date of 12/12/2022 stated the purpose of the policy was to investigate the cause of all marks, discolorations, skin breaks, and injuries that has not been witnessed. The policy stated if a licensed nurse becomes aware of an event whether it was witnessed, alleged, an injury of unknown origin, or a suspicion that abuse, neglect, or mistreatment may have occurred, immediate action will be taken. The Department of Health and other regulatory agencies will be notified as per the regulations. Resident #318 was admitted to the facility with diagnoses of Non-Alzheimer's Dementia, Depression, and Hypertension.The Minimum Data Set, dated [DATE] documented Resident #318 had severely impaired cognition. The nurse's progress note dated 07/10/2025 documented at approximately 5:00 AM, nursing staff observed Resident #318 on the floor in a supine position. Upon assessment, Resident #318 noted with a laceration on the left forehead and was unable to give account of what happened. The family and medical doctor were notified and ordered transfer to hospital for further evaluation.The Accident Incident Report dated 07/10/2025 documented on 07/10/2025 at 5:00 AM, Resident #318 was observed on the floor in a supine position, noted with a laceration on the left forehead. Resident was unable to give account of what happened. Representative and Medical Doctor were notified and ordered transfer to the hospital for evaluation and treatment. The investigation concluded there was no reasonable suspicion to believe that abuse, neglect or mistreatment occurred. The investigation summary with conclusion was signed by Director of Nursing, Administrator, and Medical Director on 07/16/2025. The Hospital Discharge summary dated [DATE] documented Resident #318 sustained a laceration to the forehead from an unwitnessed fall at the nursing home. The laceration measured 3 centimeter in length and 0.5 centimeter in depth. The laceration was repaired with 5 sutures. Resident #318 was treated and returned to the nursing home.There was no documented evidence the facility reported Resident #318's unwitnessed incident resulting to an injury to the New York State Department of Health.On 08/04/2025 at 11:54 AM, Registered Nurse #6 was interviewed and stated they were the covering nurse supervisor on the night shift on 07/10/2025 when they were notified of Resident #318's incident. Registered Nurse #6 stated Resident #318 was found on the floor next to their bed in the room and was noted with a laceration on the forehead. Resident #318 could not provide explanation about the incident. Resident #318 was ordered to transfer for hospital evaluation. Registered Nurse #6 initiated the incident report and immediately notified the Director of Nursing because the incident was unwitnessed resulted in a major injury. Registered Nurse #6 stated they do not know if this incident was reported to the Department of Health.On 08/04/2025 at 09:40 AM, the Risk Manager was interviewed and stated Resident #318 was found on the floor with a laceration on the forehead on 07/10/2025 at 5:00 AM. They stated the incident report was reviewed and determined there was no abuse or neglect that occurred with Resident #318 that was why it was not reported to the New York State Department of Health. On 08/04/2025 at 10:19 AM, the Director of Nursing was interviewed and stated they are responsible for reporting incidents involving abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neglect or incidents resulting in major injury to the New York State Department of Health. The Director of Nursing stated this incident involving Resident #318 was not reported to the New York State Department of Health because they concluded that Resident #318 sustained a laceration from a fall.On 08/04/2025 at 11:25 AM, the Administrator was interviewed and stated any reportable incidents are reported to the New York State Department of Health by the Director of Nursing or designated staff by the Director of Nursing. The Administrator stated that they worked on 07/10/2025 but does not recall this incident.10 NYCRR 415.4(b)(2)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/28/2025 to 08/04/2025, the facility failed to ensure that parenteral fluids were administered consistent with professional standards of practice. This was evident in 1 (Resident #451) of 2 residents reviewed for hydration, out of 35 total sampled residents. Specifically, Resident #451 was observed with undated peripheral intravenous catheter insertion site dressing and tubing. The intravenous solution was also not dated and was not labeled with the resident's name and flow rate. The findings include:The facility's policy and procedure titled Intravenous Infusion with a last reviewed date of 01/2022 documented that intravenous fluids should be labeled with the resident's name, the time, date, and rate of flow. The policy stated intravenous catheters are left in for no longer than 72 hours unless otherwise ordered by a physician. If intravenous therapy is ordered for greater than 72 hours, the site must be changed every 72 hours, unless otherwise indicated/ordered by a medical doctor or nurse practitioner with a reason/diagnosis.Resident #451 was admitted to the facility with diagnoses that include Seizure Disorder and Intracranial Lesions.The Comprehensive Minimum Data Set assessment dated [DATE] documented Resident #451 had severely impaired cognition and received medication administration intravenously.A physician's order for Resident #451 dated 07/27/2025 at 10:26 PM documented to infuse 1000 milliliters of Dextrose 5 percent and 0.45 percent Sodium Chloride intravenous solution every shift for 2 days for other seizures.On 07/28/2025 and 07/29/2025 at 11:48 AM, Resident #451 was observed with a left upper extremity peripheral intravenous catheter dressing that was undated, the peripheral infusion line tubing was undated and the 1-liter fluid of Dextrose with Normal saline was undated and unlabeled.A care plan for Intravenous Therapy was initiated for Resident #451 on 07/28/2025. The care plan documented Resident #454 had a need for intravenous therapy secondary to decreased fluid intake. The interventions documented to monitor the intravenous site every shift.On 07/30/2025 at 8:45 AM, Licensed Practical Nurse #4 was interviewed and stated the nursing staff who inserted the peripheral intravenous catheter should have labeled the dressing and tubing with the date so that they could be changed within 72 hours. Licensed Practical Nurse #4 also stated that they had forgotten to label the intravenous fluid bag with the resident's name, the date, and time of administration and the flow rate.On 07/30/2025 at 9:05 AM, Registered Nurse #8, who was the Nursing Supervisor, was interviewed and stated nurses should ensure that the intravenous site dressing, associated tubing or lines and hydration fluids are all labeled and dated when they are providing care, treatments and medication administration. Registered Nurse #8 further stated they performed daily rounds but missed the observation that Resident #451 had undated and unlabeled intravenous dressing, tubing and hydration bags. On 08/04/2025 at 7:59 AM, the Director of Nursing was interviewed and stated the intravenous insertion site dressing should have been labeled with the date of insertion and initials of the nurse to ensure that the dressing is changed every 72 hours. The intravenous tubing should have been labeled with the date of insertion and the intravenous hydration bags should have been labeled with resident information, date and time, and flow rate of the solution. The Director of Nursing further stated that nursing supervisors and managers should be rounding to ensure that these tasks are completed, and night supervisors should be documenting observations of resident care and treatments on an observation checklist. The observation checklist was requested but not provided.10 NYCRR 415.12(k)(2)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/28/2025 to 08/04/2025, the facility failed to ensure that food were served at a safe and appetizing temperature. This was evident for 1 (Unit 5) of 13 units observed. Specifically, on 07/30/2025, foods served during breakfast in Unit 5 were not maintained at palatable and appetizing temperature. The findings include:The facility's policy and procedure titled Food Temperature Policy with a last revision date of 05/2025 documented all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 140-degree Fahrenheit. The facility's policy titled Food Temperature Policy with a last revision date of 05/2025 documented the purpose of the policy was to ensure all meals are consistently prepared and served in a manner that is appealing in taste, texture, aroma and presentation, promoting resident satisfaction and nutritional intake.Resident #20 was admitted to the facility with diagnoses include Diabetes Mellitus, Hypertension and End Stage Renal Disease. The Minimum Data Set assessment dated [DATE] documented Resident #20 was cognitively intact and independent for eating.During an interview on 07/29/2025 at 09:01 AM, Resident #20 stated hot foods were delivered at lukewarm temperature most of the time and sometimes hot foods were cold.n 07/30/2025 at 07:46 AM, test trays for Unit 5 were requested. On 07/30/2025 at 08:25 AM, meal carts arrived on Unit 5 and distribution of the meal trays continued until 08:57 AM.On 07/30/2025 at 08:57 AM, the food temperatures on the test trays were conducted with the Food Service Director. The following were observed:For the regular diet tray, oatmeal had a temperature of 112 degrees Fahrenheit, cheddar eggs at 94 degrees Fahrenheit, and coffee 132 degrees Fahrenheit.For the puree diet tray, cinnamon oatmeal had a temperature of 120 degrees Fahrenheit, puree turkey at 90 degrees Fahrenheit, and purees eggs at 100 degrees Fahrenheit.On 08/01/2025 at 10:19 AM, the Food Service Director was interviewed and stated the temperatures were not appropriate for hot foods during the temperature checks on 07/30/2025. The Food Service Director stated the ideal temperature for hot foods should be above 140 degrees Fahrenheit. On 08/04/2025 at 10:19 AM, the Director of Nursing stated they have not heard of any food related issues until recently. On 08/04/2025 at 11:22 AM, the Administrator stated they were recently hired and was not aware of any food quality issues prior to the current survey.10 NYCRR 415.14(d)(1)(2)