STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335611	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Island Center for Nursing and Rehabilitation	490 Pelham Road New Rochelle, NY 10805

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey (NY00349917, NY00347905) and a partial extended survey the facility did not ensure the residents representative was informed of a significant change in the resident's physical status or a need to alter treatment significantly for 3 out of 4 residents (Resident #1, Resident #6, Resident #7) reviewed for notification of changes. Specifically, (1) Resident #1 developed multiple facility acquired pressure ulcers to their right buttocks on 6/20/2024 and bilateral heels on 6/25/2024. There was no documented evidence that Resident #1's representative was notified of these changes in the resident's condition until they inquired about them on 6/26/2024 and 7/1/2024. (2). Resident #6 developed a facility acquired sacral pressure ulcer on 7/27/2024. There was no documented evidence of Resident #6's representative was notified that the resident developed a sacral pressure ulcer or informed of the ordered treatment. (3) Resident #7 developed a facility acquired pressure ulcer to their sacrum on 8/21/2024. The facility documented a telephone conference with Resident #7's representative on 8/22/2024, but there was no documented evidence that Resident #7's representative was made aware that the resident developed a Stage III right buttock pressure ulcer or informed of ordered treatment. The findings are: The facilities Notification Policy dated 9/2017 and last revised on 6/2019 documented it was to ensure that residents and/or resident's representative receive notification of specific changes during the resident's stay in the facility. The facility must immediately inform the resident, consult with the resident's physician, and notify, consistent with his/her authority, the resident representative when there is: a significant change in the resident's physical status or a need to alter treatment significantly. 1) Resident #1 admitted to the facility initially on 12/7/2018 and last readmitted on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, Muscle Wasting Atrophy and Muscle Weakness. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5-day Minimum Data Set (an assessment tool that measures health status) dated 6/11/2024 documented the resident had a Brief Interview for Mental Status (a screening tool that assess a person's cognitive health) score of 12 indicating moderate cognitive impairment. Documented the resident required moderated assistance for eating, dependent for toileting, maximal assistance for bed mobility and transfers. The resident was at risk for pressure ulcers with no documented staged pressure ulcers or unstageable pressure ulcers. Documented the resident did not have any dressings applied to their feet but received ointment or medication to areas other than their feet. Review of a risk for skin integrity impairment care plan initiated 6/5/2024 documented related to decrease in mobility, Resident #1's skin would be free from pressure related injury through the next review date. Interventions listed included assist with turning and positioning as needed, heel protectors and keep resident clean and dry. During a telephone interview on 10/15/2024 at 12:12 PM Resident #1's representative stated, they visited the resident, and they noticed the resident's foot was wrapped in a bandage, no one at the facility mentioned why the foot was wrapped. The representative stated a family member visited the resident in the facility and during the visit the nurse came in the room and applied cream to the resident's buttocks. The representative stated they asked what was going on and Registered Nurse #1 stated Resident #1 had bed sores. Stated the facility had never informed them that Resident #1 had bed sores prior, and they visited the resident daily, except for 2 days during the duration of their stay in the facility. The representative stated Resident #1's roommates family brought their attention to the resident's bandaged foot and asked them what was going on with the resident's foot. The representative stated they went to Registered Nurse #1 and asked what was going on, and the nurse stated Resident #1 had a bedsore. The representative stated they saw that Resident #1 was more and more wrapped up as they visited, and that bandages were getting larger in size. Review of the Resident #1's admission assessment dated [DATE] documented the resident's skin was intact and they had dryness and skin discoloration to bilateral heels. The resident was scored as a low-pressure ulcer risk. Review of a nurse progress note dated 6/20/2024 documented Resident #1 was noted with an open wound to the left upper buttock measuring at 4 cm x 5 cm. Documented a dressing was applied and the nursing supervisor was made aware. Review of a nurse's progress note dated 6/24/2024 documented red and purple discoloration noted on left heel measuring 2 cm x 2 cm x 0 cm. Red to purple discoloration noted to right heel with measurement 6 cm x 7 cm x 0 cm, skin intact. Both heels were cleansed with normal saline, patted dry, then skin prep wipes were applied as skin protectant. Applied bilateral heel booties for offloading and unit Manager made aware. Review of nurse's progress note dated 6/25/2024 documented Resident #1 was noted to have a skin tear on their right lower buttocks which measured 2 cm x 2 cm x 0.1 cm, with scant serosanguinous drainage. The right lower buttocks were cleansed with normal saline, patted dry, and xeroform dressing applied then site covered with a dry protective dressing, unit manager made aware. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nurse's progress note dated 6/26/2024 documented Resident #1's daughter approached them about the residents dressing that is wrapped on their foot, and they informed them that the resident's bilateral heels are being treated with skin prep and wrapped for additional protection. The complainant also asked about the skin openings on Resident #1s buttocks, and they informed them it is being treated by the wound care nurse. Documented the complainant also expressed concern about the time it takes before the resident is attended to by staff when the certified nurse assistant is with another resident. Review of a nurse note dated 6/27/2024 documented they were informed by Registered Nurse #2 wound care nurse that Resident #1 was observed with a skin opening on their right heel, a deep tissue injury measuring 6 cm. The right heel was cleansed with normal saline, patted dry, and xeroform dressing applied, then covered with a dry protective dressing, until seen by wound specialist. Review of Registered Nurse #1's progress note dated 7/1/2024 documented the resident's representative approached them regarding the wound on their buttocks. They asked how frequent Resident #1 was being seen by the wound specialist. The note documented that they informed the representative that the resident was being assessed by Registered Nurse #2 wound care nurse every day and would be evaluated by the wound specialist weekly. There was no documented evidence that the facility notified Resident #1's representative of the changes in their condition, prior to the representative inquiring. During a telephone interview on 10/18/2024 at 11:32 AM Registered Nurse #1, they stated they were the unit manager on 1 West. Registered Nurse #1 stated as the unit manager they are responsible to notify the family if there are any changes in condition or wounds or any changes in the resident health status. Registered Nurse #1 stated, they were not sure if they were working the day Resident #1's wound was discovered. They further stated that, if they were not working then the nursing supervisor on duty would be responsible to notify the family. Registered Nurse #1 stated whomever is the nurse assigned to a resident at the time of discovery would inform them or the nursing supervisor of any changes and they would contact the family on the same day. Registered Nurse #1 stated that Resident #1's family was in the facility daily and was notified about the development of the wounds. Registered Nurse #1 stated when they are at the nurse's station, they provide updates to family representatives when they ask about the residents. Review of the staffing schedule for June 20th and 21st revealed Registered Nurse #1 was on schedule. During an interview on 10/21/2024 at 3:50 PM the Director of Nursing stated the Registered Nurse #1 was very familiar with Resident #1's family who were in the facility daily and they are not sure why Registered Nurse #1 did not notify the family about the resident's pressure ulcers. 2) Resident #6 initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including but not limited to Muscle Wasting and Atrophy, Type 2 Diabetes Mellitus and Bipolar Disorder. A 5-day Minimum Data Set (an assessment tool that measures health status) dated 8/28/2024 documented the resident had severe cognitive impairment. The resident had a facility acquired Stage III pressure ulcer to their sacrum. Pressure relieving devices in use in bed and wheelchair. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a pressure ulcer care plan initiated 7/31/2024 documented Resident # 6 had a sacral pressure ulcer on their sacrum that was a Stage II. The goal was the pressure ulcer would show signs of healing and remain free from infection through the review date. Review of a nurse's progress note dated 7/27/2024 documented made aware by nurse on duty that Resident #6 had a skin tear on their right buttock. Physician made aware and ordered to apply xeroform daily and a wound consult. Review of a wound care note dated 7/31/2024 documented Resident #6 was seen for a new wound development a Stage II pressure ulcer noted to the sacrum measuring at 0.8 cm x 0.5 cm x 0.1 cm. The treatment plan was to cleanse with normal saline, apply collagen to wound and cover with a bordered gauze and change daily. All preventive measures discussed with staff at visit. Review of Resident #6's wound assessment reports documented that on 08/07/2024 Resident #6 had a facility acquired sacrum pressure ulcer Stage II that developed on 7/27/2024. It documented on 08/14/2024 facility acquired ulcer to the sacrum worsened to a Stage III measuring at 1.5 cm x 2.5 cm x 0.10 cm. It further documented worsening on 08/28/2024 where the facility acquired ulcer to the sacrum was now a Stage III measuring at 1.5 cm x 3 cm x 0.20 cm. On 09/11/2024 the report documented the facility acquired ulcer to the sacrum was now a Stage III measuring at 1 cm x 2.5 cm x 0.10 cm. Review of Resident #6's progress notes revealed there was no documented evidence of the representative being made aware of the facility acquired wound developing on 7/27/2024 or the treatment ordered on 7/31/2024. There was also no documented evidence of the representative being made aware of the changes in size to the wound or the stage category. 3) Resident #7 initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including but not limited to Chronic Pulmonary Embolism, Gastrointestinal Hemorrhage, and other Lack of Coordination. A Quarterly Minimum Data Set (an assessment tool that measures health status) dated 8/2/2024 documented the resident moderate cognitive impairment. The resident required moderate assistance with eating and bed mobility and was dependent for toileting and transfers. Foley catheter in pace and frequently incontinent of bowels. Documented the resident has moisture associated skin damage. A Discharge Minimum Data Set (an assessment tool that measures health status) dated 9/3/2024 documented Resident #7 had a Stage III facility acquired pressure ulcer. Review of a potential for pressure ulcer development care plan initiated 8/16/2022 documented Resident #7 would have intact skin by/through the review date. Interventions listed included inform the resident family of any new areas of skin breakdown and interventions initiated 10/21/2024 listed assist with turning and positioning every 2 hours and as needed, administer treatments as ordered. Review of a wound progress note dated 8/14/2024 Resident #7 was seen for a rash to their buttocks and was noted to have moisture associated skin damage measuring at 1.5 cm x 1 cm x 0.1 cm. The treatment plan was to cleanse with soap and water, apply medical grade honey and cover with a bordered gauze. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a wound progress note dated 8/21/2024 documented Resident #7 was seen for a bilateral buttock rash which is now a stage III to the right buttocks. Review of a nurse's progress note dated 8/21/2024 documented Resident #7 was seen by the wound care Nurse Practitioner, moisture associated skin damage was now categorized as a stage iii pressure ulcer to the right buttocks. Unit manager on duty made aware. Review of Resident #7's wound assessment reports documented the following: on 8/14/2024 Resident #7 had moisture associated skin damage to their bilateral buttocks measuring 1.5 cm x 1 cm x 0.10 cm. The treatment ordered to cleanse daily with soap and water and apply medical grade honey and cover with a bordered gauze. The report documented on 8/21/2024 a stage III pressure ulcer to the right buttocks measuring 1.8 cm x 0.6 cm x 0.10 cm. On 8/28/2024 it documented a stage III pressure ulcer to the right buttocks measuring 1.2 cm x 0.6 cm x 0.10 cm. On 9/11/2024 the report documented a stage III pressure ulcer to the right buttocks measuring 3.0 cm x 4.0 cm x 0.10 cm. On 9/18/2024 it documented a stage III pressure ulcer to the right buttocks measuring 2.2 cm x 2.0 cm x 0.10 cm. On 9/24/2024 the report documented a stage III pressure ulcer to the right buttocks measuring 2.2 cm x 2.0 cm x 0.10 cm. Review of a care plan meeting progress note dated 8/22/2024 documented a phone conference was held with Resident #7's representative, and they were made aware of a recent urology consult and foley catheter change. Resident #7's representative was provided with updates from the team regarding diet, weight, and rehabilitation and informed Resident #7 was functioning at baseline, and the resident was on a maintenance program. There was no documented evidence of Resident #7's daughter being made aware of the resident's stage III right buttock pressure ulcer or treatment ordered. During an interview on 10/21/2024 at 3:50 PM the Director of Nursing stated family notification must be done at least within 24 hours of identification of pressure ulcer and this should be documented in the nurse's progress note and discussed during the care plan meeting. During an interview on 10/21/2024 at 4:30 PM the Administrator they stated it is their expectation that resident's families are notified of changes in their condition immediately following any incidents, issues and discoveries. 10 NYCRR 415.3(f)(2)(ii)(c)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00349917, NY00347905), the facility did not ensure the comprehensive care plans were reviewed and revised in a timely manner for 2 of 4 residents (Resident #7, Resident #8) reviewed for care planning. Specifically, Resident #7 developed a facility acquired stage II pressure ulcer to their right buttocks on 8/21/2024. There was no documented evidence of the potential for pressure ulcer development care plan being revised to reflect the actual pressure ulcer. (2) Resident #8 developed a facility acquired stage III pressure ulcer to their sacrum on 8/14/2024. There was no documented evidence of the potential for pressure ulcer development care plan being revised to reflect the actual pressure ulcer. Findings include: Review of the facility Care Planning Process dated 1/1/2018 and last revised 1/1/2023 documented the facility shall have a care planning process in place which includes integrating assessment findings in care planning, developing and interdisciplinary care plan, regularly reviewing and revising the care plan, providing the care, and documenting the care. 1) Resident #7 had diagnoses including but not limited to Chronic Pulmonary Embolism, Gastrointestinal Hemorrhage, and other Lack of Coordination. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 10 /15 associated with moderate cognition impairment. The resident required moderate assistance with eating and bed mobility and was dependent for toileting and transfers. Foley catheter in place and frequently incontinent of bowels. The resident has moisture associated skin damage. A Discharge Minimum Data Set, dated dated dated [DATE] documented Resident #7 had a Stage III facility acquired pressure ulcer. Review of a potential for pressure ulcer development care plan initiated 8/16/2022 documented Resident #6 would have intact skin by/through the review date. Interventions listed included inform the resident family of any new areas of skin breakdown and interventions initiated 10/21/2024 listed assist with turning and positioning every 2 hours and as needed, administer treatments as ordered. There was no documented evidence of Resident #7's potential for pressure ulcer development care plan being revised to reflect an actual pressure ulcer on 08/21/2024. 2) Resident #8 had diagnoses including but not limited to Nontraumatic Intracerebral Hemorrhage, other Encephalopathy and Muscle Wasting and Atrophy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview for Mental Status score of 03/15 associated with severe cognition impairment. The resident had impairment of upper and lower extremities on both sides and was dependent for eating, toileting, bed mobility and transfers. The resident was a high risk for pressure ulcers but had no skin conditions noted. Review of a risk for skin integrity impairment care plan initiated 8/14/2024 documented Resident #8 would be free from pressure related injuries by the next review date. Interventions listed included assist with turning and positioning as needed and turn and position every 2 hours. The care plan did not include an actual facility acquired stage III pressure ulcer to their sacrum. During an interview on 10/17/2024 at 12:04, Registered Nurse #2 stated prior to the new wound care company starting, the unit manager would put in a wound care consult order and provide them with the document. The Nurse Practitioner or Physician Assistant would then see the resident on wound rounds. Registered Nurse #2 stated they were responsible for documenting the findings during wound rounds in the resident's charts and updating the care plans. During an interview on 10/17/2024 at 2:10 PM, the Director of Nursing stated there was a transition from June 24th to July 5th with the wound care providers and the wound rounds were done by Registered Nurse #2, and the attending physician was notified of the findings. The Director of Nursing stated Registered Nurse #1's treatments and measurements would be reflected in their nurse's progress notes and on the resident's care plans. During a telephone interview on 10/18/2024 at 11:32 AM, Registered Nurse #1 stated Registered Nurse #2 would be the one to update the residents care plans for the resident's seen on wound rounds. Registered Nurse #1 stated Registered Nurse #2 would document in their progress notes and update the care plans if there was a significant change in the Resident's wounds. 10 NYCRR 415.11 (c)(2)(i-iii)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey and partial extended survey (NY00349917), the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent new ulcers from developing and promote healing of facility acquired pressure ulcers for 3 out of 5 residents (Resident #1, #7, #8) reviewed. Specifically, (1) Resident #1 was admitted to the facility with intact skin and was identified as a low risk for pressure ulcer development. Interventions/measures ordered by the physician to prevent pressure ulcer development were not consistently provided by direct care staff and Resident #1 developed a facility acquired pressure ulcer to their sacrum and bilateral heels. (2) Resident #7 developed a facility acquired Stage III pressure ulcer (a full thickness tissue loss where subcutaneous fat is visible within the wound, but bone, tendon, or muscle are not exposed) to the right buttocks after not receiving consistent incontinence care. (3) Resident #8 developed a facility acquired Stage III pressure ulcer to their sacrum. Resident #8 had upper/lower extremity impairment was dependent on staff for bed mobility and was not consistently provided skin observations or turning and positioning by direct care staff. Findings include: The facility's Pressure Injury/Pressure Ulcer Assessment, Prevention and Management policy dated 7/2018 documented it is the policy of the facility that residents will not develop pressure injury/ulcers unless clinically unavoidable. The facility shall provide care and service consistent with professional standards of practice to prevent pressure injury development. The purpose of the policy is to provide guidelines for the prevention as well as timely identification and treatment of pressure injury. When a pressure injury is present on an in-house resident, document the assessment of the wound on a weekly basis on the weekly evaluation form, update the pressure injury care plan to reflect the status of the pressure injury and plan of care. 1) Resident #1 was readmitted to the facility on [DATE] with diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease (lung disease causing restricted airflow and breathing problems), Muscle Wasting and Atrophy (the loss of muscle mass and strength, often occurring due to lack of use, injury, malnutrition, or certain diseases, resulting in a decrease in muscle size and function) and Muscle Weakness (lack of muscle strength). A 5-day Minimum Data Set (an assessment tool) dated 6/11/2024 documented the resident had moderate cognitive impairment. The resident required moderate assistance for eating, maximum assistance for bed mobility/transfers and was dependent for toileting. The resident was at low risk for pressure ulcers. There was no documented staged pressure ulcers or unstageable pressure ulcers. The resident had no dressings applied to their feet but received ointment or medication to areas other than their feet for dryness. Review of the Resident #1's admission/readmission nursing assessment dated [DATE] revealed the resident's skin was intact and they had dryness and skin discoloration to their bilateral heels. The Admission/Readmission assessment categorized Resident #1 as a low risk for pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of a risk for skin integrity impairment care plan initiated 6/5/2024 identified risks related to decreased mobility and documented Resident #1's skin would be free from pressure related injury through 6/25/2024. Interventions listed included assist with turning and positioning as needed, heel protectors and keep resident clean and dry. Review of an activities of daily living care plan dated 6/6/2024 revealed self-care performance deficit related to activity intolerance. Interventions listed included inspect skin every shift and observe for redness and open areas and report changes to the nurse. Toilet every 2 hours and as needed. The Admission Braden Scale (a risk assessment tool that predicts a patient's likelihood of developing pressure ulcers) dated 6/7/2024 documented Resident #1 had a score of 15 and was categorized as low risk for pressure ulcers. Review of an actual skin integrity impairment care plan initiated on 6/21/2024 documented on 6/19/2024 Resident #1 had a skin tear (a wound that occurs when the layers of skin separate due to mechanical forces, such as friction, shear or blunt trauma) to their right buttock measuring 4 cm x 5 cm. Interventions listed included apply treatment to site as ordered and prevent excessive moisture to other body parts. Review of Registered Nurse #2/wound care nurse's progress note dated 6/25/2024 documented Resident #1 was noted to have a skin tear on their right lower buttocks which measured 2 cm x 2 cm x 0.1 cm with scant serosanguinous (contains or relates to both blood and liquid part of blood) drainage. There was no further documented tracking of Resident #1's right buttock skin tear on the care plan after 6/21/2024 and no wound assessment documented in the nursing progress notes after 6/25/2024. Review of a pressure ulcer care plan initiated 6/24/2024 documented on 6/21/2024 Resident #1 had a right heel deep tissue injury (a type of pressure ulcer that occurs when the tissue beneath the skin is damaged by pressure or shearing force) 6.5 cm x 4 cm and redness to the left heel 6 cm x 4 cm. Interventions listed included assess/record/monitor wound healing weekly, turn/reposition at least every 2 hours or more as needed or requested, and wound care consults as ordered. Review of a nurse's progress note dated 6/24/2024 documented discoloration noted to right heel measuring 6 cm x 7 cm x 0 cm. Red and purple discoloration noted on left heel measuring 2 cm x 2 cm x 0 cm. Skin was noted to be intact. There was no documented evidence of a weekly skin assessment of the wound. There was no documented evidence of an updated pressure ulcer care plan related to Resident #1's heels after 6/24/2024. Review of Registered Nurse #2/wound care nurse's progress note dated 6/27/2024 documented they were informed Resident #1 had an opening to their right heel deep tissue injury measuring 6 cm. Treatment will be applied until Resident #1 is seen by wound specialist. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of Registered Nurse #2/wound care nurse's skin/wound care progress note dated 7/9/2024 documented Resident #1 was noted with redness on their right bunion measuring 2 cm x 2 cm and red to purple discoloration on their right outer ankle measuring 1 cm x 1 cm. There is no documented evidence Resident #1 was evaluated by the wound specialist prior to their transfer to the hospital on 7/12/2024 for evaluation of left facial droop. Resident #1 was discharged to the hospital on 7/12/2024. Hospital records revealed the resident had a stage 3 pressure ulcer to the sacrum and 2 pressure ulcers to the right malleolus (ankle), and the right heel. The right heel pressure ulcer was debrided (a medical procedure that removes dead, damaged, or infected tissue from a wound to promote healing). The infectious diseases evaluation documented proposed diagnosis as sepsis with source being right heel necrosis. Review of Resident #1's certified nurse assistant accountability report for June 2024 revealed the following care was not provided: bilateral heel booties in place when in bed every shift - no documentation on six (6) occasions, skin observation of right buttock and bilateral heels every shift - no documentation on eight (8) occasions and turning and positioning every two (2) to four (4) hours - no documentation on 24 occasions. Review of Resident #1's certified nurse assistant accountability report for July 2024 revealed no documented evidence indicating care, as per the care plan, was implemented: bilateral heel booties in place when in bed on 5 occasions, skin observation of right buttock and bilateral heels on 2 occasions and turning and positioning on 12 occasions. During an interview on 10/17/2024 at 12:04 PM with Registered Nurse #2/wound care nurse, they stated when Resident #1 went to the hospital in July 2024, they had facility acquired wounds on their right buttocks and on bilateral heels. Registered Nurse #2/wound care nurse stated Resident #1 was not able to move around on their own and they were turned and repositioned by the certified nurse assistants. Registered Nurse #2/wound care nurse stated Resident #1 was not turned and positioned frequently enough, and their heel booties were not applied as ordered. Registered Nurse #2/wound care nurse stated interventions such as the turning and positioning and heel booties are entered on the care Kardex and the certified nurse assistants sign off on them when completed. During a telephone interview on 10/18/2024 at 11:32 AM, Registered Nurse #1 stated when Resident #1 was admitted to the facility, they had redness to their heels, and they developed a deep tissue injury. During an interview on 10/18/2024 at 1:18 PM, Registered Nurse #3 stated they did Resident #1's admission assessment on 6/5/2024 and the resident's skin was intact with some discoloration on their heels. Registered Nurse #3 stated the discolored areas were blanchable (pressing on the area will turn the redness white or pale) and very dry and there were no signs that their heels would turn into pressure ulcers. On admission Resident #1 had no skin breakdown on their sacrum. Registered Nurse #3 stated they were concerned about the dryness to Resident #1's heels, and they activated their admission order set which included: applying antiseptic to the sacrum, using bilateral heel booties, certified nurse assistants were to elevate the resident's bilateral legs with pillows and to report any skin changes or openings to the Registered Nurse or nursing supervisor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 10/21/2024 at 2:20 PM, Certified Nurse Assistant #2 stated they remember Resident #1, and they recall repositioning the resident and applying their heel booties. Certified Nurse Assistant #2 stated an empty signature box on the certified nurse assistant accountability report looks like the care was not provided but they do not recall if they signed for Resident #1's care after completion. They usually do their documentation. During an interview on 10/21/2024 at 3:41 PM, Certified Nurse Assistant #3 stated they worked in the facility for about 3 years, and they remember Resident #1. The resident needed assistance with Activities of Daily Living care and turning and positioning in bed. Resident #1 also needed heel booties and pillows for positioning every 2 hours. Certified Nurse Assistant #3 stated if there is no signature in a box on the certified nurse accountability report then the care was not provided. Certified Nurse Assistant #3 stated they provided care to Resident #1 as ordered and cannot recall why they did not sign the accountability record. During an interview on 10/21/2024 at 3:50 PM, the Director of Nursing stated the residents are assessed to identify their risk factors for pressure ulcers and the Braden scale assessment is conducted weekly for 4 weeks for each resident after admission. Pressure relieving devices as well as heel booties and incontinence products are provided for all residents . The Director of Nursing stated all comorbidities are monitored and regulated from admission to lower risks of acquiring pressure ulcers. Upon identification of a pressure ulcer the physician is notified for a treatment order, the resident's plan of care is reviewed, preventative measures are implemented, and the residents are added to the list for wound rounds. 2) Resident #7 admitted on [DATE] with diagnoses including but not limited to Chronic Pulmonary Embolism (a medical condition that occurs when blood clots in the pulmonary arteries do not dissolve or are left untreated), Gastrointestinal Hemorrhage (a medical condition when a bleeding occurs within the gastrointestinal tract) , and Benign Prostatic Hyperplasia (a medical condition that causes the prostate to enlarge) without lower urinary symptoms. A last Quarterly Minimum Data Set (an assessment tool that measures health status) dated 8/2/2024 documented the resident had moderate cognitive impairment. The resident required moderate assistance with eating and bed mobility and was dependent for toileting and transfers. Foley catheter in place and frequently incontinent of bowels and has MASD (moisture associated skin damage). Review of a Registered Nurse #2 wound progress note dated 8/14/2024 documented Resident #7 was seen for a rash to their buttocks and was noted to have moisture associated skin damage measuring at 1.5 cm x 1 cm x 0.1 cm. Review of a wound progress note dated 8/21/2024 documented Resident #7 was seen for a bilateral buttock rash which is now a Stage III pressure ulcer to the right buttocks measuring 1.8 cm x 0.6 cm x 0.1 cm. Review of Resident #7's wound assessment reports revealed the following: - On 8/14/2024 the wound assessment report documented Resident #7 had moisture associated skin damage to their bilateral buttocks measuring 1.5 cm x 1 cm x 0.10 cm. The treatment ordered to cleanse daily with soap and water and apply medical grade honey and cover with a bordered gauze. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- On 8/21/2024 the wound assessment report documented a Stage III pressure ulcer to the right buttocks measuring 1.8 cm x 0.6 cm x 0.10 cm. - On 8/28/2024 Stage III pressure ulcer to the right buttocks measuring 1.2 cm x 0.6 cm x 0.10 cm. - On 9/11/2024 Stage III pressure ulcer to the right buttocks measuring 3.0 cm x 4.0 cm x 0.10 cm. - On 9/18/2024 and 9/24/2024 documented a stage III pressure ulcer to the right buttocks measuring 2.2 cm x 2.0 cm x 0.10 cm. Review of Resident #7's treatment administration records for August 2024 and September 2024 revealed the physician ordered treatments were not documented as completed on 8/26/2024, 8/31/2024, 9/1/2024 and 9/3/2024. Review of a potential for pressure ulcer development care plan last updated 10/21/2024 documented Resident #7 would have intact skin by/through 11/21/2024. Interventions listed included to assist with turning and positioning every two (2) hours and as needed. Review of a bladder incontinence care plan initiated on 8/16/2022 documented Resident #7 will remain free of complications related to urinary incontinence such as skin breakdown. Interventions listed included assist with toileting as requested and check the resident every two (2) to four (4) hours and as needed as required for incontinence. There were no documented updates to the interventions on the bladder incontinence care plan. A target date of 11/21/2024 was documented. Review of the foley catheter care plan, last updated 8/19/2024, listed interventions to change catheter every four (4) weeks, monitor intake and output, position catheter bag and tubing below the level of the bladder. Review of Resident #7's certified nurse assistant accountability report for August 2024 revealed the following care was not provided: skin observation of sacrum and bilateral buttocks every shift - not documented on 31 occasions, bladder incontinence care every shift - not documented on 31 occasions. Review of Resident #7's certified nurse assistant accountability report for September 2024 revealed the following care was not provided: skin observation of sacrum and bilateral buttocks every shift - not documented on 36 occasions, bladder incontinence care every shift - not documented on 30 occasions. 3)Resident #8 was admitted with diagnoses including but not limited to Nontraumatic Intracerebral Hemorrhage (a type of stroke that occurs when blood pools in the brain without trauma or surgery), other Encephalopathy (any brain disease that alters brain function or structure) and Muscle Wasting and Atrophy (the loss of muscle mass and strength, often occurring due to lack of use, injury, malnutrition, or certain diseases, resulting in a decrease in muscle size and function). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	An Admission Minimum Data Set (an assessment tool that measures health status) dated 8/7/2024 documented the resident had moderate cognitive impairment. The resident had upper and lower extremities impairment and was dependent for eating, toileting, bed mobility and transfers. The resident was a high risk for pressure ulcers but had no skin conditions noted. Review of Resident #8's Admission/Reassessment nursing assessment dated [DATE] documented the resident's skin was intact and categorized them as a low risk for pressure ulcers. Review of Registered Nurse #1's progress note dated 8/11/2024 documented they were informed by the certified nurse assistant that Resident #8 had a wound to their sacral area. Resident noted to have a superficial skin opening to the sacral area measuring 0.5 cm x 0.5 cm x 0.1 cm. Review of the wound care Nurse Practitioner's progress note dated 8/14/2024 documented Resident #8 had a Stage III pressure ulcer to the sacrum measuring 0.6 cm x 0.2 cm x 0.1 cm. Review of a risk for skin integrity impairment care plan initiated 8/14/2024 documented Resident #8 would be free from pressure related injuries by 12/21/2024. Interventions listed included assist with turning and positioning as needed and turn and position every two (2) hours. Review of Resident #8's certified nurse assistant accountability report for August 2024 revealed the following care was not provided: skin observation every shift - not documented on 41 occasions and turning and positioning every two (2) hours - not documented on 53 occasions. Review of Resident #8's certified nurse assistant accountability report for September 2024 revealed the following care was not provided: skin observation every shift -not documented on 39 occasions and turning and positioning every two (2) hours -not documented on 160 occasions. Review of Treatment Administration Record for August/September 2024 revealed wound treatments for the Stage III pressure ulcer were not documented as completed on the following dates: 8/18/2024, 8/22/2024, 8/31/2024, and 9/1/2024. During an interview on 10/21/2024 at 2:13 PM, Certified Nurse Assistant #1 stated if their signature was not in the box, then it would look as if they did not provide the care, but they make rounds on their residents regularly and sometimes, they forget to sign off on their tasks in the computer, because they get caught up in their work. During an interview on 10/21/2024 at 3:50 PM, the Director of Nursing stated the expectation is the certified nurse assistants complete their documentation for all residents assigned before the end of their shift. It is the responsibility of the unit managers to check the documentation and notify the certified nurse assistants of incomplete documentations. The Director of Nursing stated the certified nurse assistants can go back and document any missed information. The last In-service on documentation was completed 10/20/2024. The Director of Nursing stated they have not received any recent complaints from the residents about not receiving care, and there have been no complaints regarding care from the families in the past. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	During an interview on 11/25/2024 at 10:13 AM, Registered Nurse #2/wound care nurse stated they were not wound care certified but are in the process of taking online seminars. Registered Nurse #2/wound care nurse stated when they assess a wound and it is superficial, they categorize it as a skin tear, meaning it is affecting only the epidermal layer (the outermost layer) of the skin. These wounds are pressure ulcers, but the Nurse Practitioner must categorize them as such. Registered Nurse #2/wound care nurse stated they are not allowed to stage the wounds if they are not sure of the staging. Registered Nurse #2/wound care nurse stated they initiate the initial treatment plan per the facility protocol until the wound Nurse Practitioner comes in and stages the wound. The wound Nurse Practitioner is the one who does the staging of the wounds. During an interview on 11/25/2024 at 11:21 AM, the Director of Nursing stated Registered Nurse #2/wound care nurse can stage a wound, but they are scared to stage. The Director of Nursing stated they even provided Registered Nurse #2/wound care nurse with different terms to describe the wounds. The nurses are very good at identifying and treating the wounds, but they need to build their confidence to stage the wounds. The Director of Nursing stated Registered Nurse #2/wound care nurse was re-educated to determine the cause of the wound, because that is how they can identify pressure from non-pressure injuries. The Director of Nursing stated Registered Nurse #2/wound care nurse and all staff in the facility were provided education last month by a wound care company. The Director of Nursing also stated Registered Nurse #2/wound care nurse has attended training on wounds for the last 2 consecutive months. During a telephone interview on 11/21/2024 at 11:55 AM, the Medical Director stated they are aware of the facility acquired pressure ulcers in the facility and that there is a wound care specialist team that provides service in the building. The Medical Director stated the wound care specialist team works very closely with nursing and the Director of Nursing. The nurses communicate any concerns and issues about wounds to them. The Medical Director stated they see an incredible service being provided by the wound care specialist team and that there is always room for improvement with the facility acquired pressure ulcers. The Medical Director stated residents need to be checked constantly/around the clock for their incontinence needs, skin condition and wound status. If a resident has fragile skin, the resident needs to be turned and positioned and have their incontinence brief changed frequently to avoid skin breakdown. On admission, residents are assessed by the admitting nurse. If there is the need for wound care, a verbal order is given by them to the nurse. Verbal orders are also given for turning and repositioning. The Director of Nursing is in constant communication with the wound care consultants to follow through with recommendations provided. The Medical Director stated that turning and repositioning is part of their preventative measures/protocol to minimize facility acquired pressure ulcers, which is done with or without orders from them. The Medical Director stated with any wound or skin issue that occurs, the nurses are expected to institute turning and positioning as per protocol. All measures must be written on the physician orders for final signature including orders as per the facility protocol such as turning/repositioning/skin observations/heel booties. 10 NYCRR 415.12

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey (NY00347905) the facility did not ensure that a resident with urinary incontinence received appropriate treatment and services for 4 out of 4 residents (Resident #6, #9, #3, #4) reviewed for incontinence care. Specifically, (1) Resident #6 was incontinent and was dependent on direct care staff for toileting. Review of Resident #6's certified nurse assistant accountability report for July and August 2024 revealed numerous signature omissions for bladder incontinence care indicating care was not provided by direct care staff. (2) Resident #9 was known to be frequently incontinent of urine and always incontinent of bowel. Review of Resident #9's certified nurse assistant accountability report for June and July 2024 revealed there were numerous signature omissions indicating bladder incontinence care was not provided by direct care staff. (3) Resident #3 was incontinent and dependent on direct care staff for toileting. Review of Resident #3's certified nurse assistant accountability for August and September 2024 revealed numerous signature omissions for bladder incontinence care indicating care was not provided by direct care staff. (4) Resident #4 was frequently incontinent of bladder and required supervision with toileting. Review of Resident #4's certified nurse assistant accountability for August and September 2024 revealed there were numerous signature omissions indicating bladder incontinence care was not provided by direct care staff. The findings are: The facilities Incontinence Care policy last reviewed 5/2024 documented the purpose is to at preserves resident dignity, promote cleanliness, and prevent infection, remove irritating and odorous secretions, and prevent extended skin exposure to incontinence of urine and feces. Incontinence care will be provided after each incontinence episode. Resident's will be checked every 2 hours depending upon each resident's needs/patterns. More frequent checking, example hourly, may be required if the resident is having acute frequent episodes of urine or bowel incontinence related to acute change in condition. 1)Resident #6 initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including but not limited to Muscle Wasting and Atrophy, Type 2 Diabetes Mellitus and Bipolar Disorder. A 5-day Minimum Data Set (an assessment tool that measures health status) documented the resident had severe cognitive impairment. The resident had impairment to both upper and lower extremities on both sides and was dependent for eating, toileting, bed mobility and transfers. The resident was always incontinent of bladder and bowel and had a facility acquired Stage III pressure ulcer to their sacrum. Review of a bladder incontinence care plan dated 10/11/2018 documented Resident #6 had frequent incontinence related to impaired mobility and medication side effects. The goal was the resident would remain free of complications related to incontinence such as skin breakdown and urinary tract infections through 12/5/2024. Interventions listed included assist resident with toileting as requested and check resident every 2-4 hours, as needed and as required for incontinence. Wash, rinse and dry perineum and change clothing as needed after incontinence episodes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's certified nurse assistant accountability report for July 2024 revealed there was no signature indicating the following cares were provided: bladder incontinence-occasional incontinence care on 6 occasions, apply bilateral heel booties and elevate heel when in bed on 11 occasions. Review of Resident #6's certified nurse assistant accountability report for August 2024 revealed there was no signature indicating the following cares were provided: bladder incontinence-occasional incontinence care on 6 occasions, apply bilateral heel booties and elevate heel when in bed on 6 occasions. 2) Resident #9 admitted to the facility on [DATE] with diagnoses including but not limited to Metabolic Encephalopathy, Bipolar Disorder and Type 2 Diabetes. A Modification of Admission 5-day Minimum Data Set (an assessment tool that measures health status) dated 7/1/2024 documented the resident was cognitively intact and exhibited rejection of care behavior. The resident had impairment to the upper extremity on one side and used a walker and a wheelchair for locomotion. The resident required supervision for eating, dependent for toileting, maximal assistance for bed mobility and transfers. Resident was frequently incontinent of urine and always incontinent of bowel. Review of Resident #9's certified nurse assistant accountability report for June 2024 revealed there was no signature indicating the following care was provided: bladder incontinence-occasional incontinence care on 5 occasions. Review of Resident #9's certified nurse assistant accountability report for July 2024 revealed there was no signature indicating the following care was provided: bladder incontinence-occasional incontinence care on 16 occasions. 3) Resident #3 admitted to the facility on [DATE] with diagnoses including but not limited to Acquired Absence of Left Great Toe, Chronic Myeloid Leukemia and other Abnormalities of Gait and Mobility. A Quarterly Minimum Data Set (an assessment tool that measures health status) dated 8/8/2024 documented the resident was cognitively intact. The resident had limited range of motion to the lower extremities and required a wheelchair for locomotion. The resident required supervision for eating, was dependent for toileting, moderate assistance for bed mobility and maximal assistance with transfers. The resident was occasionally incontinent of bladder and frequently incontinent of bowel. Review of Resident #3's certified nurse assistant accountability for August 2024 revealed bladder incontinence care was not signed as being provided by direct care staff on 49 occasions. Review of Resident #3's certified nurse assistant accountability for September 2024 revealed bladder incontinence care was not signed as being provided by direct care staff on 31 occasions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/21/2024 at 9:15 AM Resident #3 stated they are independent mostly but use incontinence briefs at night and when they urinate in their incontinence brief, they will ring their call bell, and the certified nurse assistants may or may not come. Resident #3 stated they go to bed at 9 PM and no one comes and attends to them until 9 AM. Stated this happens often and they have not reported this to the unit manager. Resident #3 stated the incontinence brief they had on currently was soaked with urine, and that they had urinated in it 2 or 3 times overnight, and now after 9 AM they still had the same incontinence brief on. 4)Resident #4 admitted to the facility on [DATE] with diagnoses including but not limited to Unspecified Dementia, Type II Diabetes Mellitus and Acquired of Right Leg Below the Knee. A Quarterly Minimum Data Set (an assessment tool that measures health status) documented the resident was cognitively intact. The resident had limited range of motion in one lower extremity and required a wheelchair for locomotion. The resident required set-up assistance for eating, supervision for toileting and transfers and was independent for bed mobility. The resident was frequently incontinent of bladder and bowel. Review of Resident #4's certified nurse assistant accountability for August 2024 revealed bladder incontinence care was not signed as being provided by direct care staff on 54 occasions. Review of Resident #4's certified nurse assistant accountability for September 2024 revealed bladder incontinence care was not signed as being provided by direct care staff on 39 occasions. During an interview on 10/21/2024 at 9:25 AM Resident #4 stated they are left in their incontinence brief for 9 hours or more at a time. During an interview on 10/21/2024 at 2:06 PM Certified Nurse Assistant #6 they always provide cares to their assigned residents. Stated a blank signature box on the certified nurse assistant accountability signifies the task was not completed and they thought they had signed for all of their assigned resident's tasks. During an interview on 10/21/2024 at 2:13 PM Certified Nurse Assistant #1 stated if their signature is not in the box, then it would look as if they did not provide the care. Certified Nurse Assistant #1 stated they make rounds on their residents regularly, but sometimes they forget to sign off for their tasks in the computer, because they get caught up in their work. During an interview on 10/21/2024 at 3:50 PM the Director of Nursing stated the expectation is that the certified nurse assistants will complete their documentation before the end of their shift and check to ensure they have documented on all the residents they were assigned to. Stated they have not had any complaints recently from the residents about complaints regarding not receiving care from the staff. Stated it was not really an issue in the past and that they had not gotten any complaints from the families. 10 NYCRR 415.12(d)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during a partial extended survey (NY00349917, NY00347905), the facility did not provide sufficient nursing staff to consistently meet the needs of all residents. The Facility Assessment resident to staff ratios (certified nurse assistant) levels were frequently below the levels determined by the facility to be necessary to meet the needs of the residents. Specifically, review of the unit staff assignment sheets for June 2024, July 2024, August 2024 and September 2024 revealed staffing was not adequate across various shifts based on the unit needs and the staffing needed as documented in the facility assessment. The findings are: The facility Staffing Assignments policy dated 7/9/2007 and last reviewed 7/21/2024 documented the policy of the facility to determine the appropriate staffing on a unit based on the census, acuity, shift and needs of the residents. The purpose of the policy is to ensure that each floor is staffed with sufficient competent staff each shift. Review of the Facility assessment dated [DATE] and revised 10/18/2024 and reviewed by the Quality Assurance Performance Committee in the 3rd Quarter revealed the following staffing levels for certified nurse assistants per shift per unit: For the 7 AM to 3 PM shift per each unit in the facility is as follows: 1 West-4 certified nurse assistants, 1 East-5 certified nurse assistants, 2 West-5 certified nurse assistants. The 3 PM to 11 PM certified nurse assistant per shift for unit 1 [NAME] was 3 certified nurse assistants, for 1 East-4 certified nurse assistants for 2 [NAME] was 2 certified nurse assistants. The 11 PM to 7 AM shift certified nurse assistant per unit for 1 West-2 certified nurse assistants, 1 East-3 certified nurse assistants, 2 West-2 certified nurse assistants Review of the Certified Nurse Assistant Assignment staffing assignment sheets for June 2024 revealed the following: On the 1 [NAME] unit-2 certified nurse assistants for the 11 PM to 7 AM shift on the following days: 6/1/2024 to 6/4/2024, 6/6/2024 to 6/24/2024 and 6/26/2024 to 6/30/2024. On the 1 East unit-4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 6/2/2024, 6/15/2024, 6/17/2024, 6/22/2024 to 6/24/2024, 6/26/2024 and 6/30/2024. On the 1 East unit 3 certified nurse assistants for the 3 PM to 11 PM shift on the following days: 6/3/2024, 6/7/2024, 6/9/2024, 6/10/2024, 6/11/2024, 6/13/2024, 6/14/2024, 6/16/2024 to 6/24/2024, 6/27/2024, 6/29/2024 and 6/30/2024. 1 certified nurse assistant on 6/23/2024. 2 certified nurse assistants on 6/1/2024 to 6/4/2024, 6/6/2024 to 6/11/2024, 6/14/2024 to 6/18/2024, 6/20/2024 to 6/22/2024, 6/24/2024 to 6/27/2024, 6/29/2024 and 6/30/2024. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2 [NAME] unit 4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 6/2/2024, 6/3/2024, 6/9/2024, 6/15/2024 to 6/17/2024 and 6/21/2024 to 6/30/2024. 2 certified nurse assistants for the 11 PM to 7 AM on the following days: 6/1/2024 to 6/11/2024, 6/13/2024 to 6/15/2024, 6/17/2024, 6/23/2024 to 6/28/2024 and 6/30/2024. Review of the staffing assignment sheets for July 2024 revealed the following: On 1 [NAME] 3 certified nurse assistants for the 7 AM to 3 PM shift on 7/7/2024, 1 certified nurse assistant on the 11 PM to 7 AM shift on 7/24/2024 On 1 East 4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 7/5/2024 to 7/9/2024, 7/13/2024, 7/14/2024 and 7/28/2024. 3 certified nurse assistants for the 3 PM to 11 PM shift on the following days:7/4/2024 to 4/8/2024, 7/11/2024, 7/12/2024, 7/14/2024, 7/21/2024, 7/23/2024, 7/24/2024 to 7/28/2024 and 7/31/2024.2 certified nurse assistants for the 11 PM to 7 AM shift on the following days: 7/2/2024 to 7/18/2024, 7/20/2024, 7/22/2024 to 7/24/2024, 7/26/2024 and 7/28/2024 to 7/31/2024. 1 certified nurse assistant for the 11 PM to 7 AM shift on 7/21/2024 and 7/27/2024 On 2 [NAME] 4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 7/3/2024, 7/5/2024 to 7/11/2024, 7/13/2024, 7/14/2024, 7/20/2024, 7/21/2024, 7/25/2024, 7/27/2024 to 7/29/2024 and 7/31/2024. 1 certified nurse assistant on the 11 PM to 7 AM shift on the following days: 7/4/2024 and 7/10/2024 Review of the staffing assignment sheets for August 2024 revealed the following: On 1 [NAME] 3 certified nurse assistants for the 7 AM to 3 PM shift on 8/21/2024. On 1 East 4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 8/4/2024, 8/11/2024 and 8/31/2024. 3 certified nurse assistants for the 3 PM to 11 PM shift on the following days: 8/2/2024, 8/4/2024, 8/6/2024, 8/8/2024, 8/12/2024, 8/13/2024, 8/16/2024, 8/17/2024, 8/18/2024, 8/20/2024, 8/22/2024, 8/23/2024, 8/25/2024, 8/26/2024 and 8/29/2024. 2 certified nurse assistants for the 11 PM to 7 AM shift on the following days: 8/2/2024 to 8/16/2024, 8/18/2024, 8/19/2024, 8/21/2024, 8/24/2024, 8/25/2024, 8/27/2024 to 8/31/2024 On 2 [NAME] 4 certified nurse assistants for the 7 AM to 3 PM shift on the following days: 8/4/2024, 8/9/2024, 8/11/2024, 8/12/2024, 8/18/2024, 8/20/2024, 8/23/2024 to 8/25/2024 and 8/30/2024. 1 certified nurse assistant for the 11 PM to 7 AM shift on 8/6/2024. Review of the staffing assignment sheets for September 2024 revealed the following: On 1 [NAME] 2 certified nurse assistants for the 3 PM to 11 PM shift on 9/9/2024 On 1 East 3 certified nurse assistants for the 3 PM to 11 PM shift on the following days: 9/3/2024, 9/8/2024, 9/16/2024, 9/20/2024, 9/22/2024 and 9/29/2024. 2 certified nurse assistants for the 11 PM to 7 AM shift on the following days: 9/1/2024 to 9/4/2024, 9/6/2024 to 9/13/2024, 9/15/2024, 9/16/2024, 9/19/2024 to 9/22/2024 and 9/24/2024 to 9/30/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335611	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Island Center for Nursing and Rehabilitation	490 Pelham Road New Rochelle, NY 10805

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2 [NAME] 4 certified nurse assistants for the 7 AM to 3PM shift on the following days: 9/8/2024, 9/16/2024, 9/21/2024, 9/23/2024, 9/28/2024 and 9/29/2024 During an interview on 10/18/2024 at 2:01 PM, the Administrator stated they have been with the company for 6 years. The Administrator stated in the facility assessment they have included that the facility had recently began a certified nursing assistant training program in the facility. The Administrator stated the students receive hands on training in the facility and are trained by the facility, these students are then hired in the facility as support staff. The Administrator stated the support staff assist with the following tasks: bed making, runners for residents and basic nominal things like helping with putting on clothing protectors. The Administrator stated the certified nurse assistant school has helped them with retaining staff in the facility as these students when they finish the program, work in the facility as certified nurse assistants. During an interview on 11/25/2024 at 12:02 PM, the Payroll/Accounts payable staff stated their previous title was Staffing Coordinator for [AGE] years. The Payroll/Accounts payable staff stated the staffing now is good, the number of staff has increased. The Payroll/Accounts payable staff stated during and after COVID staff did not want to return to work, facility started a certified nurse assistant school, and this helped with increasing the staffing levels. The Payroll/Accounts payable staff stated they will ask the staff in-house if they can stay for the shift or call another staff to come in. The Payroll/Accounts payable staff stated they would call someone first and if they are running out of time then they will go to the units and ask staff if they can stay. Review of the schedule for 11/25/2024 during on site visit revealed the schedule is short a certified nurse assistant on the night shift, stated the staffing coordinator will try to find someone to fill the shift before the shift. 10NYCRR 415.13 (A)(1)(i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49372 Based on record review and interviews during an abbreviated survey (NY00349917, NY00347905), the facility did not ensure a performance review was completed for every nurse aide at least once every 12 months, and that regular in-service education was provided based on the outcome of these reviews for 2 of 7 records reviewed. Specifically, (1) Certified Nurse Assistant #7 with a date of hire of 4/28/2015 had no documented annual performance evaluations prior to 11/22/2023 and none for 11/22/2024. (2) Certified Nurse Assistant #8 with a date of 8/1/2014 did not have any documented annual performance evaluations in their personnel file prior to 11/22/2023 and none foe 11/22/2024. The Findings are: The Facility Performance Review policy last reviewed 9/2/2024 documented all written performance reviews will be performed annually based on the staff member's overall performance in relation to the job responsibilities and will also consider the staff member's conduct, demeanor, and record of attendance and tardiness. The most recent evaluation supersedes prior evaluations. Review of the Facility Performance Evaluation revealed they were not based on the in-service education required per year. The annual in-service education was also not completed for the employees according to their employment date in the facility. Review of Certified Nurse Assistant #7's in-service log attendance sheet revealed their last in-service date was 3/14/2024. Certified Nurse Assistant #7 received 5 hours mandatory training on 3/14/2024. Certified Nurse Assistant #7's last performance review provided by the facility was dated 11/22/2023. Their date of hire was 4/28/2015. There were no other documented performance reviews in the employees file and the facility did not provide additional performance reviews for this employee. Review of Certified Nurse Assistant #8's in-service log attendance sheet revealed their last in-service was on 3/14/2024 and had received 9 hours of training by 8/27/2024. Certified Nurse Assistant #8's last performance review provided by the facility was dated 11/22/2023. Their date of hire was 8/1/2014. There were no other documented performance reviews in the employees file and the facility did not provide additional performance reviews for this employee. During an interview on 11/25/2024 at 2:42 PM, the Human Resources Director stated each employee has one personnel file and that some of the employee documents are not filed due to renovations, but once the renovations are completed the files will be updated. The Human Resources Director stated competencies and performance evaluations are maintained in the employee personnel files and they have a binder with all staff performance evaluations. The Director of Human Resources stated the performance evaluations are completed annually for current employees, and there is also a 90-day evaluation for new employees. The Director of Human Resources stated they manage the general resources portion such as: fire safety, corporate compliance, resident's rights, and abuse prevention. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/2024 at 3:57 PM, the Director of Nursing stated they completed an audit in 2022 and found the annual performance evaluations were not being completed timely, so at that point the facility decided to start fresh and reevaluate all staff for their annual performance. The Director of Nursing stated the audit was done in November 2023, and now all staff will have their annual performance evaluations completed timely. The Director of Nursing stated the performance evaluations are currently in progress and will be submitted to them after completion. The Director of Nursing stated there was no established tracking of the staff performance evaluations prior to November 2023 but now they use excel spreadsheet to all staff evaluations that are due and assigns them to the nurses for completion. 10 NYCRR 415.26

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated and partial extended survey (NY00349917, NY0034705), the facility did not ensure the Quality Assessment and Performance Improvement committee developed and implemented appropriate plans of action to correct identified quality deficiencies. Specifically, (1) there were no documented evidence of the facilities actionable plans being implemented for their identified facility acquired pressure ulcer issue; (2) there was also no documentation of the continued performance improvement plan for 2 areas discussed in the 2nd quarter meeting. The findings are: The facility Quality Assurance and Performance Improvement Program policy documented the purpose was to ensure the development of a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality care, quality of life and resident safety. The facility must document the development, implementation and evaluation of corrective actions or performance improvement activities. Review of the 2nd quarter Quality Assurance and Performance Improvement documentation dated 7/24/2024 listed the following areas of concern: Call light audit and delayed Minimum Data Set assessments. There was no documented evidence of a performance improvement plan being reviewed or included in the 3rd quarter Quality Assurance and Improvement meeting agenda or minutes. Review of the 3rd Quarter Quality Assurance and Improvement meeting documentation dated 10/30/2024 submitted by the facility included the sign-in sheet, a copy of the weekly skin tracker/quality assurance report dated 11/5/2024 and 11/7/2024, and a list of residents identified on admission with pressure ulcers. The departmental reports provided by the facility as part of the Quality Assurance and Improvement Meeting were dated 11/13/2024. The Quality Assurance and Performance Improvement agenda for the 10/30/2024 meeting referenced facility acquired pressure ulcers, the facility did not provide the Quality Assurance and Performance Improvement plan for facility acquired pressure ulcers. There were no documented details or plans and processes on how the facility would prevent facility acquired pressure ulcers. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/2024 at 3:18 PM, the Administrator stated that the facility acquired pressure ulcers were discussed in the last Quality and Assurance Performance Improvement meeting on 10/30/2024. When asked when the meeting took place, the Administrator stated the last Quality Assurance and Performance Improvement meeting was set for 10/30/2024, but something happened, and the meeting did not occur. The Administrator stated the sign-in sheet for the meeting was already dated for 10/30/2024 and was not re-done to reflect the actual date of the meeting which was 11/13/2024. All the documentation from the meeting was dated 11/13/2024 because that is the day the meeting actually took place. The Administrator stated the performance improvement plan for facility acquired pressure ulcers would be presented in the next Quality Assurance and Performance Improvement meeting with the internal audit identifying [NAME] and a plan of correction for the issue. The Administrator stated the plan to address the issues was already in process but there is no documented action plan for the identified issues, from the 11/130/2024 meeting. The Action plan from the 11/13/2024 meeting will be discussed at the next Quality Assurance and Performance Improvement meeting. The Administrator stated they would inform the Social Worker to include the performance improvement plans with percentages of compliance until the issues are resolved. 10NYCRR 415.27(a-c)