STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335621	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
United Hebrew Geriatric Center	391 Pelham Road New Rochelle, NY 10805

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview the facility did not ensure a Notice of Medicare Non-Coverage is given by the facility to all Medicare beneficiaries at least two days before the termination of services for one (1) of three (3) residents (Resident #194) reviewed for Beneficiary Notification. Specifically, there was no documented evidence that Resident #194 and/or their representative received and signed a two (2) day Notice of Medicare Non-Coverage before termination of services. The findings include: Resident #194 was admitted with diagnoses including unspecified dementia, atherosclerotic heart disease and unspecified atrial fibrillation. The 09/10/2025 admission Minimum Data Set (an assessment tool) documented Resident #194 had severe cognitive impairment, received 100 minutes of occupational therapy and 130 minutes of physical therapy. The 10/20/2025 Notice of Discharge/Transfer documented Resident #194 would be discharged on 10/24/2025.The Beneficiary Protection Notification Review form documented by the former social worker revealed Resident #194's last covered day of Medicare Part A Services was 10/23/2025 and the facility/provider-initiated discharge from Medicare Part A Services when benefit days were not exhausted. There was no documented evidence that Resident #194 and/or their representative received and signed a Notice of Non-Coverage for Medicare Part A Services two (2) days prior to end of services.Resident #194 was discharged from the facility on 10/24/2025.During an interview on 12/09/2025 at 12:11 PM, the Director of Social Work stated there was a meeting to discuss Resident #194's discharge date and the family wanted the resident to go home. They stated that a signed Notice of Medicare Non-Coverage could not be found for Resident #194. 10 NYCRR 415.3 (g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility did not ensure that drugs and biologicals were maintained in accordance with current professional standards for storage, labeling and expiration dates during review of medication storage on two (2) of four (4) units. Specifically, 1) observation of the fourth-floor medication cart revealed one (1) insulin pen with no open date and one (1) insulin pen with no patient label and no open date. The fifth-floor medication cart revealed two (2) insulin pens which had not been discarded within 28 days after opening as per the manufacture's recommendation, and 2) a physician ordered Trelegy Ellipta (inhaler) was left in Resident #155's room on the bedside table. The findings include: 1) The 8/2020 policy titled Administration Procedures for All Medications documented when opening a multidose container, place the date on the container. During observation on 12/02/2025 at 10:51 AM, the medication cart on unit 4 Skalet revealed one Lantus Solostar insulin pen labeled with Resident # 5's name which had no open date and one Admelog insulin pen with no resident name label and no open date. During a 12/02/2025 at 10:51 AM interview, Registered Nurse #8 stated whoever opened the insulin pen was responsible for writing the date the insulin was opened. They stated insulin pens were viable for 28 days after they were opened. During a 12/02/2025 at 11:33 AM interview, Registered Nurse/Charge Nurse #9 stated sometime the nurses forget to date insulin pens when they open them. They further stated a pharmacy consultant audited carts and medication pass with the nurses. During observation on 12/02/2025 from 12:33 PM -12:37 PM, the medication carts on the 5 Skalet unit revealed one Lantus Solostar insulin pen with Resident #169's' name which had an open date of 10/24/2025 and had not been discarded within 28 days as per the manufacture's recommendation, and one Lantus Solostar insulin pen with Resident #127 's name which had an open date of 10/27/2025 and had not been discarded within 28 days as per the manufacture's recommendation. During a 12/09/2025 at 10:48 AM interview, the Director of Nursing stated there was no excuse for the insulin pens not having a date to indicate when they were opened, and insulin pens should be discarded 28 days after opened per pharmacy recommendations. They stated nurses should check open dates before they administer insulin. During a 12/09/2025 at 11:09 AM interview, the Infection Preventionist stated they had a lesson plan that covered when an insulin pen was opened, it should be labeled with an open date. They stated the education had been provided once since they started at the facility and there was a skills test upon orientation which was to be reviewed yearly. 2) Resident #155 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, and respiratory failure. The 06/21/2023 physician order documented Trelegy Ellipta 100-62.5-25MCG powder, inhale one (1) puff daily at 10 AM (self-administration) (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 06/19/2024 and 06/21/2024 document titled Resident Participation Agreement for Self-Administration of Medication Program signed by Resident #155, Registered Nurse Unit Manager #17, Nurse Practitioner and Medical Doctor #2, documented when the medication was not in their possession, they agreed to store the medication in the locked closet/drawer in their room. The 10/15/2025 Annual Minimum Data Set (resident assessment) documented Resident #155 was cognitively intact. The 11/04/2025 comprehensive care plan titled Resident Wishes to Self-Administer Medication documented assess the resident for competency and re-evaluate as needed. During observations and interviews on 12/02/2025 at 11:44 AM and 12:52 PM, Resident #155 was sitting in a wheelchair in their room. A Trelegy Ellipta inhaler was lying on Resident #155's over-bed table. Resident #155 stated that they took one (1) puff once daily. Resident #155 was unable to state how long the inhaler had been in the room. During observation on 12/02/2025 at 02:11 PM, Resident #155 was awake while lying in bed. A Trelegy Ellipta inhaler was lying on Resident #155's over-bed table. During an interview on 12/03/2025 at 01:17 PM, Licensed Practical Nurse #16 stated the inhaler which was already in Resident #155's room, was set up by them so that Resident #155 could self-administer the inhaler. They stated they then left the room. Licensed Practical Nurse #16 stated when they returned to the room, Resident #155 told them they self-administered their inhaler. Licensed Practical Nurse #16 stated they left the inhaler in Resident #155's room and were not aware that the inhaler should be locked in a drawer or cabinet. Licensed Practical Nurse #16 stated they were not aware of whether the room had a locked drawer to store the inhaler. During an interview on 12/05/2025 at 12:00 PM, Registered Nurse Manager #17 stated they were not aware the inhaler should be locked in a drawer or cabinet and had not educated the nurses on securing the inhaler. Registered Nurse Manager #17 stated that Resident #155 was evaluated for self-administration in June 2023 and was re-evaluated annually by Medical Doctor #2 and Nurse Practitioner. They reviewed the facility's self-administration program and reviewed the self-administration agreement, and stated that according to the agreement, the medication must be stored in a locked drawer or locked box in the resident's room. Registered Nurse Manager #17 stated Resident #155 did not have a locked drawer in their room, therefore the medication should have been stored in the medication cart. 10NYCRR 415.18(d) (e) (1-4)