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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER: Teresian House Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 Washington Ave Ext Albany, NY 12203	

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 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** 51742 Based on interviews and record review during the recertification survey and an abbreviated survey (Case #NY00346710), the facility did not ensure that (a.) all alleged violations of resident abuse, neglect, exploitation, or mistreatment, 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 resulted in serious bodily injury, to the administrator of the facility and to other official (including the State Survey Agency and adult protective services where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures; and (b.) reported the results of all investigations to the administrator or their designated representative, and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident for 2 (Resident #s88 and 144) of 5 residents reviewed for reporting of allegations. Specifically, for (a.) Resident #88 received a wrong medication and the initial report was submitted more than 24 hours after the incident; (b.) Resident #141 sustained a fracture to the left hand on 8/18/2024, and then another fracture to the right wrist diagnosed on [DATE], neither severe injury was reported to the State Survey Agency. In addition, a 5-day investigation report was not submitted when . This is evidenced by: A facility policy, Abuse Prevention Program, last revised 10/20/2022 documented that the facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provided for jurisdiction in long-term care facilities) in accordance with State law through established procedures. It further documented to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident and if the alleged violation is verified appropriate corrective action must be taken. Under the section titled What to Report, it documented both Federal and State regulations require the reporting of alleged violations of abuse, mistreatment, and neglect, including injuries of unknown origin. The administrator would provide the appropriate agencies or individuals listed above with a written report of the finding of the investigation within five working days of the occurrence of the incident. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 225; Issued 08-08-2024) documents that injuries should be classified injuries of unknown source when all of the following criteria are met: the source of the injury was not observed by any person, and the source of the injury could not be explained by the resident, and the injury is suspicious because of a. the extent of the injury or b. the location of the injury or c. the number of injuries observed at one particular point in time or d. the incidence of injuries over time. It further documents that examples of injuries of unknown source that were required to report: unobserved/unexplained fractures, sprains or dislocations, unobserved/unexplained swelling that is not linked to a medical condition, and unobserved/unexplained injury requiring transfer to a hospital for examination and/or treatment. Resident #88 Resident #88 was admitted to the facility with diagnosis of Alzheimer's dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), osteoarthritis (degenerative disease that worsens over time, often resulting in chronic pain. Joint pain and stiffness) and history of falls. The Minimum Data Set (an assessment tool) dated 10/03/2024, documented the resident could not complete the Brief Interview for Mental Status due to severely impaired cognition; it further documented that the resident could rarely/never be understood and could rarely/never understand others. The Medication Error or Discrepancy Report dated on 6/27/2024 at 9:50 AM documented Licensed Practical Nurse #7, in error administered the following medications prescribed for another resident to resident #88: Morphine Sulfate 5 milligrams sublingual, Lantus insulin injection 10 units, Keppra 5 milligrams orally, Lasix 40 milligrams orally, metoprolol 25 milligrams orally and Miralax 17 grams mixed with fluid orally. The Incident Report submission form documented that the Director of Nursing reported the medication error on 6/28/2024 at 1:35 PM to the State Survey Agency. It further documented that the Administrator was first made aware of the incident on 6/27/2024 at 10:20 AM. There was no documented evidence of 5-day investigation report for this incident (NY00346710) was submitted to the Department of Health. During an interview on 11/08/2024 at 3:15 PM, Director of Nursing #1 stated that someone from the department of health called about the intake that was submitted and the Director of Nursing believed the department of health had all of the information and no 5-day report was needed. In addition, they said they did not get an email with a link to complete the 5-day report. During an interview on 11/08/2024 at 3:38 PM, Administrator #1 stated they were with Director of Nursing #1 when the department of health called, and the Administrator did not get an email with the link to submit a 5-day investigation report and that was the only way to submit a 5-day report to the Administrator's knowledge. Resident #141 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #141 was admitted to the facility with the diagnoses of adjustment disorder with mixed disturbance of emotions and conduct (difficulty adjusting to new situations causing changes in emotions and behaviors), dementia with psychotic disturbance (a degenerative neurological disease causing memory loss and significant behavior changes), and age-related osteoporosis (weakening of bone density related to aging). The Minimum Data Set, dated dated dated [DATE] documented the resident was able to be understood, understand others, and was significantly cognitively impaired. Facility's Incident Report #757 dated 8/18/2024 at 1:52 PM documented that Resident #141 was noted to have swelling and a darkened area between the left thumb and left index finger and the resident complained of pain when it was touched. The resident was not able to describe what happened, but they were observed using the inner part of the wheelchair to propel instead of the outer wheel. It documented that an x-ray of the left hand reflected a displaced fracture of the fifth metacarpal (bones that connect wrist to fingers). Facility's Incident Report #805 dated 9/04/2024 at 3:00 PM documented that Resident #141 was observed on the floor and was unable to state what happened due to dementia. The resident was assessed, and no injury was found, and range of motion was intact without pain. There were no documented evidence of reported incidents involving injury of unknown origin reported for Resident #141 to the Department of Health. A Progress Note dated 9/10/2024 at 4:56 PM documented that Resident #141 had 2 skin discolorations on the left facial area due to the fall on 9/04/2024. A Skin Evaluation note dated 9/16/2024 at 12:58 PM documented that skin color was within normal limits and no issues were documented. A Skin Evaluation note dated 9/23/2024 at 2:19 PM documented that skin color was within normal limits and no issues were documented. A Progress Note dated 9/26/2024 at 8:31 PM documented that Resident #141 had swelling to the right mid lateral forearm, right elbow and right index finger, no recent trauma, and pain when palpated. A Progress Note dated 9/27/2024 at 8:59 AM documented a new order for an x-ray to the right forearm, wrist, hand, and fingers. A Progress Note dated 9/27/2024 at 12:55 PM documented that because Resident #141 had no fall since 9/4/2024, the present fracture was determined to be a direct result from the fall on 9/4/2024. A Progress Note dated 9/27/2024 at 7:54 PM documented that Resident #141 was sent to the emergency room at 3:50 PM. A Progress Note dated 9/28/2024 at 5:13 AM documented that Resident #141 returned from the emergency room with a new diagnosis of a closed fracture of the distal end of the right ulna (wrist) and a cast. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/2024 at 2:26 PM, Director of Nursing #1 stated that when a fall or injury occurs the nursing staff would notify the Director of Nursing, and the Director of Nursing would determine if they looked suspicious and if so it would be reported within 2 hours. They stated just because Resident #141 could not describe what happened and it was not witnessed does not mean it was suspicious and required to be reported in their understanding. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 51742 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure a Significant Change Minimum Data Set assessment was completed for a 1 (Resident #141) of 42 residents reviewed for significant changes in health status. Specifically, Resident #141 sustained a fractured wrist on 8/18/2024, and a fracture of the other wrist on 9/27/2024 after a fall on 9/04/2024. There was no documented evidence that a significant change assessment was done. This is evidenced by: The policy Change in a Resident's Condition or Status, revised 3/3/2023, documented that if a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the Minimum Data Set Resident Assessment Instrument instruction manual. Resident #141 was admitted to the facility with the diagnoses of adjustment disorder with mixed disturbance of emotions and conduct (difficulty adjusting to new situations causing changes in emotions and behaviors), dementia with psychotic disturbance (a degenerative neurological disease causing memory loss and significant behavior changes), and age-related osteoporosis (weakening of bone density related to aging). The Minimum Data Set (an assessment tool) dated 10/18/2024 documented the resident was able to be understood, understand others, and was significantly cognitively impaired. It further documented that Resident #141 had no major injuries from a fall, and the definition of major injury included bone fracture. A nursing assessment note dated 8/18/2024 at 12:43 PM documented that the resident was observed to have left hand discoloration, swelling and complaints of pain. A nursing note dated 8/19/2024 at 11:12 AM documented that the resident had a left- hand fracture due to the incorrect use of their wheelchair. An x-ray dated 8/19/2024 showed a fracture of the 5th metacarpal (palm bone) on the left distal side that was slightly displaced. A follow up note dated 8/19/2024 at 3:48 PM documented that a brace was ordered by orthopedics and the resident was referred to physical therapy for treatment. A physical therapy note dated 8/21/2024 at 4:51 PM documented that the resident would receive skilled physical therapy services 5 times a week for 4 weeks to improve transfers and functional mobility. There was no documented evidence that a Minimum Data Set assessment was done to account for the change in condition of the resident's left wrist. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 9/26/2024 at 8:31 PM documented that the resident was assessed for swelling and pain to the right forearm. A nursing note dated 9/27/2024 at 12:55 PM documented that the resident had a right hand fracture which was attributed to a fall the resident had on 9/04/2024. There was no documented evidence that a Minimum Data Set assessment was done to account for the change in condition of the resident's bilateral broken hands. During an interview on 11/08/2024 at 1:48 PM, Minimum Data Set Coordinator #1 stated that a fracture would be a significant change of condition and 2 fractures would definitely be a significant change that would require an updated Minimum Data Set (resident assessment). They stated they missed the fractures for Resident #141. They stated they were s going to look into the situation and get back with the surveyor, but no further information was provided. During an interview on 11/08/2024 at 2:26 PM, Director of Nursing #1 stated they believed a fracture was a significant change and it was the responsibility of the Minimum Data Set Coordinator to update the Minimum Data Set after a significant change. The Director of Nursing stated sometimes things get missed. 10 New York Codes, Rules, and Regulations 415.12(a)(3)

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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** 51609 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised based on changing goals, preferences, and needs for 2 (Residents #83 and #261) of 62 residents reviewed. Specifically, for Resident #s 83 and 261, the facility did not ensure an interdisciplinary care plan meeting reviewed the comprehensive care plan to include weight monitoring. This is evidenced by: The Policy and Procedure titled Change in a Resident's Condition or Status dated 04/22/2024, documented it was the facilities policy to promptly identify changes in condition, notify his or her attending physician, and the resident/representative of changes in the resident's medical/mental condition and/or status. The Interdisciplinary Team must review and update the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set assessment. The assessments of residents were ongoing and care plans were revised as information about the residents and the residents' conditions change. Resident #83 Resident #83 was admitted to the facility with the diagnoses of anxiety, Alzheimer's, and mood disorder. The Minimum Data Set (an assessment tool) dated 1/19/2024 documented the resident could rarely understand and rarely be understood by others; resident was cognitively impaired. The Comprehensive Care Plan dated 5/07/2024, documented the resident required assistance with Activities of Daily Living related to limited mobility, Alzheimer's, and inability to complete Activities of Daily Living tasks. Interventions included a shower every week. On 5/05/2022 Resident #83 was on comfort measures and per health care proxy request no weights to be obtained. The signed physician orders dated 01/22/2024 documented an order to discontinue weights and heights dated 1/08/2024. During an interview on 11/07/2024 at 11:30 AM, Resident #83's Family #1 stated they would assume the facility was weighing Resident #83 but was unsure. Family #1 stated they had been to all the care plan meetings but could not remember discussing the weight. During an interview on 11/07/2024 at 12:38 PM, Registered Nurse #5 stated they believed the weights should be gone over with residents/representatives at each family meeting. During an interview on 11/07/2024 at 12:53 PM, Social Worker #1 stated that Resident #83's family attended care planning meetings religiously. Social Worker #1 stated they were unsure why the order had been in effect for so long, they knew the providers would go over the orders and continue them or discontinue them when necessary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/2024 at 01:01 PM, Director of Nursing stated they would expect the care plan to be updated as soon as possible. The weights should be discussed at the care conference, and they also discuss weights at their meeting titled Wounds and Weights. Resident #261 Resident #261 was admitted to the facility with the diagnoses of atrial fibrillation, coronary artery disease (damage or disease in the heart's major blood vessels), and hypertension,. The Minimum Data Set, dated dated dated [DATE] documented the resident could understand and be understood by others; resident was cognitively impaired. The Comprehensive Care Plan dated 11/01/2024, documented the resident required assistance with Activities of Daily Living related to dementia. On 08/23/2024 Resident #261, per health care proxy request, no weights to be obtained. Resident #261 had altered cardiovascular status and staff were to monitor/document/report any changes in weight. Review of the Medical Charting System listed no weight within the last 90 days. Medical Charting System listed a weight of 170.8 pounds on 8/21/2024. During an interview on 11/07/2024 at 11:45 AM, Resident #261's Family #2 stated they never told the facility not to weight Resident #261 and believed they should weight them. During an interview on 11/07/2024 at 9:06 AM, Certified Nurse Aide #4 stated they obtained weights from a list provided by the unit manager, enter them in the Medical Charting System, and return the list to the unit manager. During an interview on 11/07/2024 at 12:38 PM, Registered Nurse #5 stated they believed the weights should be gone over with residents/representatives at each family meeting. During an interview on 11/07/2024 at 12:53 PM, Social Worker #1 stated that health care proxies should be asked quarterly regarding weights. During an interview on 11/08/2024 at 1:01 PM, Director of Nursing stated they would expect the care plan to be updated as soon as possible. The weights should be discussed at the care conference, and they also discuss weights at their meeting titled Wounds and Weights. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii) 51742

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F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.

48615

Based on observations, record review, and interviews during the recertification survey, the facility did not ensure a dependent resident was provided with appropriate treatment and services to maintain or improve their language and communication for 1 t (Resident #268) of 1 resident reviewed for Activities of Daily Living. Specifically, Resident #268 was not provided with an adequate, structured approach and tools to communicate effectively in accordance with professional standards of care.

This is evidenced by:

The facility's Policy on Communication with Residents with Speech Impairments reviewed on 1/24/2024, documented its purpose was to provide staff with a structured approach to communicate effectively and compassionately with residents affected by speech impediments due to stroke, ensuring clear, respectful, and supportive interactions. Procedures include use of communication aids; non-verbal cues; environment adjustments, documentation, and staff training.

The New York State Department of Health Code, Rules and Regulation, Volume C (Title 10) Section 415.3 Effective 2/24/2022, documented each resident shall have the right to: (i) adequate and appropriate medical care, and to be fully informed by a physician in a language or in a form that the resident can understand, using an interpreter when necessary, of his or her total health status including but not limited to, his or her medical condition including diagnosis, prognosis, and treatment plan. Residents shall have the right to ask questions and have them answered.

Resident #268 was admitted to the facility with a diagnoses of cerebral vascular accident (stroke), right side hemiplegia (paralysis of one side of the body), and aphasia (loss of ability to understand or express speech, caused by brain damage). The Minimum Data Set (an assessment tool) dated 9/01/2024, documented a Brief Interview for Mental Status score of 00 suggesting the assessment was incomplete. The documentation indicated resident could understand and be understood by others.

Resident's Communication Comprehensive Care Plan dated 6/2024, documented Resident #268 was dependent on staff for meeting emotional, intellectual, physical, and social needs due to physical and verbal limitations status post cerebral vascular accident (stroke) resulting in aphasia. Resident is a very social and creative person and is interested in participating in activities during their short term stay for rehabilitation. Due to recent aphasia, Resident #268 preferred activities which did not involve the need for them to verbalize. Resident is presently limited to yes/no responses to simple questions.

During an observation on 11/04/2024 at 11:53 AM, Resident #268 was observed sitting in their room in their wheelchair dozing off and on while watching television. Resident's speech was garbled and difficult to understand. Resident appeared to become frustrated when unable to express their thoughts and hold conversation.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 11:57 AM, Certified Nurse Aide #2 and Certified Nurse Aide #3 stated some of them understand resident #268. They mostly speak in short phrases with closed ended yes/no answers. They stated resident was able to nod, shake head and point. Certified Nurse Aide #2 and Certified Nurse Aide #3 stated they did not receive training on stroke or resident with dysphagia (difficulty speaking) at this facility. During an interview on 11/06/2024 at 1:03 PM, Registered Nurse #1 stated Resident #268 was able to answer yes/no questions and points to objects. They had no other means of communication. Resident at times becomes frustrated with inability to express themselves. They stated Resident #268 was currently working with speech therapy and making gains. During an interview on 11/06/2024 at 1:20 PM, Speech Therapist #1 stated they were working with Resident #268 on dysphagia (difficulty speaking) and cognitive communication, targeting expressive and receptive skills including communication partner training picture based. Resident had no pictures in room; they point to objects. They had been using the therapy department's IPAD. Resident's family would bring in an IPAD, but first needed to delete some items prior to brining to facility. They stated Resident #268 was only communicating with closed end questions yes/no answers and pointing. During an interview on 11/08/2024 at 11:17 AM, Director of Nursing #1 stated when residents were admitted with language barriers, they were assessed by speech therapy. The resident was also discussed during interdisciplinary team meeting. Communication board and picture boards were used to assist with communication. 10 New York Codes, Rules, and Regulations 415.12(a)(2)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 51609 Based on observation, record review, and interviews during a recertification survey, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene for 1 (Resident #83) of 9 residents reviewed for Activities of Daily Living. Specifically, Resident #83 was not provided assistance with personal hygiene during care leaving facial hair to grow on the upper lip. This is evidenced by: Resident #83 was admitted to the facility with the diagnoses of anxiety, Alzheimer's, and mood disorder. The Minimum Data Set (an assessment tool) dated 01/19/2024 documented the resident could rarely understand and rarely be understood by others; resident was cognitively impaired. The facility policy Activities of Daily Living Support effective 03/16/2023 documented residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The Comprehensive Care Plan dated 9/22/2023 documented the resident required assistance with Activities of Daily Living related to limited mobility, Alzheimer's, and inability to complete Activities of Daily Living tasks. Interventions included a shower every week. The following observations of Resident #83 were made: - On 11/04/2024 at 10:09 AM, resident was noted with facial hair on the upper lip. - On 11/06/2024 at 9:55 AM, resident was in the wheelchair in the room and noted to have facial hair on the upper lip. - On 11/07/2024 at 10:02 AM, resident noted with longer hair to upper lip. During an interview on 11/07/2024 at 11:30 AM, Resident #83's Family #1 stated their daughter used to provide the facial shaving for Resident #83 but cannot do it now, they would expect that staff provided the care for the facial hair. During an interview on 11/07/2024 at 10:02 AM, Certified Nurse Aide #1 stated they would shave the male residents on their shower day but did not think about shaving the female residents. They confirmed Resident #83 did have facial hair on their upper lip. During an interview on 11/07/2024 at 10:52 AM, Licensed Practical Nurse #1 confirmed Resident #83 had facial hair on their face. Licensed Practical Nurse #1 stated it was expected to be taken care of on bath days. During an interview on 11/08/2024 at 1:01 PM, Director of Nursing #1 stated they would expect all residents to receive shaving on bath days and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules, and Regulations 415.12(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335627	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
NAME OF PROVIDER OR SUPPLIER Teresian House Nursing Home CO Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Washington Ave Ext Albany, NY 12203	

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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 - Few	Provide safe and appropriate respiratory care for a resident when needed. 48413 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that were in accordance with professional standards of practice for 1 (Resident #'s 148) of 4 residents reviewed for oxygen administration. Specifically, Resident #148's portable oxygen tank ran out of oxygen. This is evidenced by: A review of the facility's policy and procedure titled Oxygen Administration, last revised on 5/09/2024, documented that oxygen would be administered by licensed nurses with a physician's order. Oxygen could be delivered via an E size oxygen tank for short-term use and when the resident was not on their concentrator. Resident #148 was admitted to the facility with diagnoses including malignant neoplasm of the right upper bronchus or lung (a cancerous tumor located in the upper lobe of the right lung, specifically within the bronchus, the airway leading to the lung lobe), acute respiratory failure with hypoxia (breathing disorder when there is not enough oxygen in the body's tissue), and essential hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 9/16/2024 documented that the resident could understand others and had intact cognition for daily living decisions. During an observation on 11/05/2024 at 11:34 AM, a portable oxygen tank on the back of Resident #148's wheelchair was set to deliver 2 liters per minute of oxygen via nasal cannula and the oxygen gauge showed the tank was in the red zone, indicating it was empty. During an observation on 11/06/2024 at 3:50 PM, a portable oxygen tank on the back of Resident #148's wheelchair was set to deliver 2 liters per minute of oxygen via nasal cannula and the oxygen gauge showed the tank was in the red zone, indicating it was empty. During the follow-up with Resident #148 and observation of their oxygen tank, Licensed Practical Nurse #8 came into the room and attempted to remove the oxygen tank from the surveyor's view. A record review for Resident #148 Medication Administration Record for November 2024 documented resident was to be on 2 liters per minute of oxygen via a nasal cannula for shortness of breath. The administration record also documented that the resident oxygen tank was to be monitored when the resident was on the portable oxygen and turned on. The oxygen tank needed to be changed when the gauge was in the red range or when necessary. During an interview on 11/06/2024 at 3:50 PM, Licensed Practical Nurse #8 stated that they were coming in to do their routine check and change the Resident #148 bottle. They stated that the oxygen tank usually lasts approximately 2-3 hours with the resident on their current oxygen flow of 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/2024 at 10:20 AM, Registered Nurse #6 stated that residents' oxygen should be checked every shift to ensure the portable oxygen tank had oxygen. They stated that the oxygen bottle should be checked whenever the resident was out of their room and not on their concentration. They stated that Certified Nurse Aides were allowed to check the level of oxygen in the tank but are not allowed to change the tank if nearing empty and would notify a nurse. Registered Nurse #6 was made aware of the observations made and the incident with the Licensed Practical Nurse. They stated that they would need to reeducate their staff regarding checking the tank for oxygen levels. 10 New York Code of Rules and Regulations 415.12(k)(6)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48615 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for 1 (Resident #77) of 4 residents observed during a medication pass for a total of 25 observations. This resulted in a medication error rate of 24%. This is evidenced by: The facility's Policy and Procedure titled Administering Medications, last reviewed 3/16/2023 and Last Revision: 11/5/2024, documented medications were administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation #2: medications may be administered within (1) hour before or after prescribed times. Scheduled medications designated as time-critical (medications that may cause harm or sub-therapeutic effect if administered before or after the scheduled time were administered at the scheduled time (for example, rapid-acting insulin) or within 30 minutes of the scheduled time. #8: The individual administering the medication checks the label THREE (3) times to verify: a. right resident, b. right medication, c. right dosage, d. right time and e. right method (route) of administration before giving the medication. Resident #77 was admitted to the facility with a diagnoses of primary generalized osteoarthritis (characterized by joint pain, stiffness, limited range of motion, and weakness); adjustment disorder with anxiety (a strong emotional or behavioral reaction to stress or trauma); and unspecified dementia (mild cognitive impairment). The Minimum Data Set (an assessment tool) dated 9/02/2024, documented resident had severe cognitive impairment, could be understood, and understand others. Resident #77's current physician orders on the Medication Administration Record dated 11/2024 revealed that the resident should receive Tylenol Extra Strength 500 milligram (Acetaminophen) give 2 tablets by mouth every 8 hours (8:00AM), and the following medications at 9:00 AM: Ferrous Sulfate 325 milligrams give 1 tablet by mouth. Finasteride 5 milligram give 1 tablet by mouth. Flomax 0.4 milligram (Tamsulosin Hydrochloride) give 1 capsule by mouth. Lidocaine External Patch, apply to right side of ribs topically in the morning and remove at bedtime. Losartan Potassium 25 milligram give 1 tablet by mouth. Senna Plus 8.6-50 milligrams give 1 tablet by mouth. During a medication observation conducted on 11/06/2024 at 10:42 AM on Mount Carmel 1st floor [NAME] Wing. Licensed Practical Nurse #3 administered the following medication at 10:50 AM: Tylenol Extra Strength 500 milligram (Acetaminophen) 2 tablets by mouth; Ferrous Sulfate 325 milligrams 1 tablet by mouth. Finasteride 5 milligram 1 tablet by mouth. Flomax 0.4 milligram (Tamsulosin Hydrochloride) 1 capsule by mouth. Lidocaine External Patch, applied to right side of ribs topically; Losartan Potassium 25 milligram 1 tablet by mouth. Senna Plus 8.6-50 milligrams 1 tablet by mouth. During an interview on 11/06/2024 at 1:30 PM, Licensed Practical Nurse #3 stated they were late with their morning medication pass because it was a heavy medication pass and they were always running late with medication. Licensed Practical Nurse #3 was asked what the policy or protocol was when they were late with medication pass. Licensed Practical Nurse #3 stated they usually ask for help but did not ask today 11/06/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/08/2024 at 11:04 AM, Nurse Educator #1 stated upon hire each nurse completed three days of general orientation. The third day of orientation was dedicated to nurse competencies including medication administration. The Nurse then was assigned a preceptor, and the orientation checklist is completed. Each nurse must pass a medication competency test. The medication competency test included the 6 rights of medication administration: a. right resident, b. right medication, c. right dosage, d. right time and e. right method (route) of administration before giving the medication. Nurse Educator #1 stated if a medication was given late the medication nurse was responsible to notify either their charge nurse and or the physician, then document in progress notes of the late medication, notification, and next steps. During an interview on 11/08/2024 at 11:17 AM, Director of Nursing #1 stated all nurses completed a medication pass competency with nurse educator and with their preceptor. It was the expectation that if a medication was late the nurse passing medication would call the physician and document in progress notes. If the medication nurse notified their charge nurse/manager of a late medication, it was the responsibility of the charge nurse/manager to notify the physician and document. During an interview on 11/08/2024 at 11:44 AM, Assistant Director of Nursing #1 reviewed the medication administration record for Resident #77 for the morning of 11/06/2024, Assistant Director of Nursing #1 verified Tylenol Extra Strength 500 milligram (Acetaminophen) was signed as given 11:10AM; and the following medications: Ferrous Sulfate 325 milligrams; Finasteride 5 milligram; Flomax 0.4 milligram; Lidocaine External Patch, apply to right side of ribs; Losartan Potassium 25 milligram; and Senna Plus 8. 6-50 milligrams were signed as given 10:50 AM. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)]

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that residents are free from significant medication errors.

48615

Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents were free of any significant medication errors for 2 (Resident #s 88 and 144) of 2 resident reviewed. Specifically, (a.) on 6/27/2024 Resident #88 received medications that were prescribed for another resident; (b.) on 11/02/2024 and 11/03/2024 Resident #144 did not receive a medication as prescribed. Additionally, there was no documented evidence that physician was notified, and that Resident #144 was monitored for side effects.

This is evidenced by:

The facility's Policy and Procedure titled Administering Medications, last reviewed 3/16/2023 and last Revision: 11/05/2024, documented medications were administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation #15: If a drug was withheld or refused, the nurse administering the medication should initial and code the space provided for that drug and dose. If resident refused medication after 3 attempts document in Electronic Medication Administration Record and report to Registered Nurse. If this occurs for 3 consecutive days, notify Medical Doctor/Nurse Practitioner. If any medication was unavailable from pharmacy, it must be reported to the supervisor and Director of Nursing.

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 211, 02-03-23) documents, under A. PROVISION OF ROUTINE AND/OR EMERGENCY MEDICATIONS: The regulation at 42 CFR 483.45 requires that the facility provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. Procedures should identify how staff, who were responsible for medication administration:

o Ensure each resident had a sufficient supply of his or her prescribed medications (for example, a resident who was on pain management had an adequate supply of medication available to meet his or her needs). At a minimum, the system is expected to include a process for the timely ordering and reordering of medication. o Monitor the delivery and receipt of medications when they were ordered; and o Determine the appropriate action, example: contact the prescriber or pharmacist, when medication(s) is not available for administration.

Resident #88:

Resident #88 was admitted to the facility with diagnosis of Alzheimer's dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), Osteoarthritis (degenerative disease that worsens over time, often resulting in chronic pain. Joint pain and stiffness) and history of falls. The Minimum Data Set (an assessment tool) dated 10/3/2024, documented the resident could not complete the Brief Interview for Mental Status due to severely impaired cognition; it further documented that the resident could rarely/never be understood and could rarely/never understand others.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Error or Discrepancy Report documented on 6/27/2024 at 9:50 AM, Licensed Practical Nurse #7, in error administered the following medications prescribed for another resident to Resident #88: Morphine Sulfate 5 milligrams sublingual, Lantus insulin injection 10 units, Keppra 5 milligrams orally, Lasix 40 milligrams orally, metoprolol 25 milligrams orally and MiraLAX 17 grams mixed with fluid orally. The Medication Administration Record dated for June 2024 documented Resident #88 should have received the following medications at 9:00 AM: Cholecalciferol 500 micrograms orally; Ferrous Sulfate 325 milligram orally; Lasix 20 milligrams orally; Loratadine 10 milligrams orally; Cardizem 60 milligram orally; Cyclosporin 0.05% eye drops, 1 drop to both eyes. The facility's Investigative Report documented on 6/27/2024 at 10:30 AM documented Medical Director #2 initiated orders to hold scheduled medications for Resident #88; start intravenous fluids of normal saline at 150 milliliters per hour for a total of 250 milliliters. A Physician's Progress Note dated 6/27/2024 at 2:16 PM, documented Resident #88 had a medication error and subsequent low systolic blood pressure (the amount of pressure experienced by the arteries while the heart is beating) 91 and Heart Rate 80 manually. They were seen and examined personally. Resident was alert, breathing comfortably, not acutely ill-appearing, no distress, no sweating, Lungs: clear with auscultation (listening). The resident had no complaints. Medical Director #2 documented would give 250 milliliters normal saline intravenously at 150 milliliters per hour for good measure. During an interview on 11/08/2024 at 2:26 PM, Director of Nursing #1 stated Resident #88 was given another resident's medication. Resident #88's scheduled medications were held, and Medical Doctor #2 ordered intravenous fluids. They stated Licensed Practical Nurse #7, who gave the wrong medication quit shortly after the incident. The staff were in-serviced to remember to verify the identity of the resident to whom they provide medication to ensure it was the correct resident. The current expectation was that staff checked the resident's bracelet before administering medication to a resident. Resident #144: Resident #144 was admitted to the facility with a diagnoses depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), and right middle cerebral artery (MCA) stroke (occurs following damage to the right distribution of the middle cerebral artery). The Minimum Data Set (an assessment tool) dated 8/02/2024, documented for the resident was cognitively intact, could be understood, and understand others. During an observation and interview on 11/04/2024 at 10:49 AM, Resident #144 stated they had not received prescribed Ingrezza for the third day. Resident #144 stated they had been up all night unable to sleep, grinding teeth with upset stomach. Resident #144 stated they were told it was to be re-ordered the previous Friday (11/01/2024) but was not ordered due to insurance pre-authorization. Review of Resident #144's Medication Administration Record dated 11/2024 documented: 11/02/2024 12:09 PM, Ingrezza Oral Capsule 40 milligrams Give 1 capsule by mouth one time a day for tardive dyskinesia - On order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/03/2024 11:13 AM, Ingrezza Oral Capsule 40 milligrams Give 1 capsule by mouth one time a day for tardive dyskinesia. Spoke with pharmacy who stated medication was on its way. 11/04/2024 10:17 AM, Ingrezza Oral Capsule 40 milligrams Give 1 capsule by mouth one time a day for tardive dyskinesia Unavailable. During an interview on 11/04/2024 at 11:03 AM, Registered Nurse #3 stated they were in process of calling the physician regarding medication that required pre-authorization by the insurance company. Registered Nurse #3 was unable to present documentation of physician notification. They stated Resident #144 had not received Ingrezza medication since Friday, 11/01/2024, and the physician was not made aware until now. During an interview on 11/04/2024 at 11:15 AM, Director of Nursing #1 sated when a medication was up for re-order, the medication nurse notifies pharmacy. If the medication was not available, the physician was notified for further direction. During an interview on 11/04/2024 at 11:45 AM, Medical Director #1 stated when a drug required prior authorization from the insurance carrier, it was difficult to obtain. It was a long process to get through to the insurance company and wait for the decision. Medical Director #1 stated if a medication was not available to be given, the physician should be notified. Medical Director #1 stated they were not made aware of the unavailable medication. If they had been notified, they would have authorized a 3-day supply to be paid by the facility, so that the patient would have medications as prescribed while awaiting insurance authorization. During an interview on 11/06/2024 at 8:40 AM, Licensed Practical Nurse #2 stated they attempted to re-order the medication on Thursday 10/31/2024 for Resident #144. However, the re-order would not go through as the medication required prior authorization. Licensed Practical Nurse #2 stated they notified Registered Nurse #3 on 10/31/2024 that drug required pre-authorization. They stated on Friday morning 11/01/2024 they administered the last pill in the packet to Resident #144 and left after their morning medication pass. 10 New York Codes, Rules, and Regulations 415.12(m)(2) 51742

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48413 Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served in accordance with professional standards for food service safety in 2 of 14 resident unit kitchenettes. Specifically, refrigerators and freezers were not operating appropriately. This is evidenced by: A review of facility policy for the environment last revised 3/04/2024 documents that the facility was to maintain a clean and safe environment. The policy documents the facility would maintain the building and all department equipment to comply with all current Federal, State, and Local regulations and guidelines. The facility should maintain a regularly scheduled maintenance on all department equipment and repair as needed. During observations on the Carmel Garden [NAME] Unit on 11/06/2024 at 10:34 AM, the resident kitchenette refrigerator flashed an E-1 error code. During observations on the second-floor west unit on 11/06/2024 at 10:46 AM, the resident kitchenette freezer had a temperature reading of 33 degrees Fahrenheit. An observation of the food within the freezer was soft and not frozen. During an interview on 11/06/2024 at 11:30 AM, Director of Dining Services and Clinical Nutrition #1 stated that Catering Assistants should check the refrigerator and freezer temperatures during their morning routine and fill out logs for the daily temperatures. During an interview on 11/06/2024 at 11:35 AM, Director of Plant Operations #1 and Life Safety #1 stated that their maintenance supervisor performs morning rounds and takes temperature readings of all refrigerators and freezers in the facility. A review of temperature logs supplied by Director of Plant Operations #1 from 10/30/2024 through 11/06/2024 documented that the Unit 2B freezer temperature taken by Plant Operation supervisor ranged from 9 degrees at its lowest to 27 degrees at its highest. When asked if their supervisor mentioned that the freezer was not getting to the appropriate temperatures, Director of Plant Operations stated that they did not mention it. A review of temperature logs supplied by Director of Dining Services and Clinical Nutrition #1 from 10/01/2024 through 11/06/2024 documented that the Unit 2B freezer temperature taken by Catering Assistant ranged from 6 degrees at its lowest on 10/10/2024 to 30 degrees at its highest on 11/06/2024. When asked if the Catering Assistant assigned to the unit mentioned that the freezer was not getting to the appropriate temperatures, Director of Dining Services and Clinical Nutrition #1 stated that they did not mention it or reported it to anyone. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 11/06/2024 at 2:30 PM, Director of Dining Services and Clinical Nutrition #1 and Director of Plant Operations #1 stated that they had taken all the items out of the freezer on the unit and discarded them. They also stated they placed an out-of-order sign on the freezer door, so it was not used. They also stated that the code flashing on the Carmel Gardens unit was an error code for an evaporator probe for the unit and they would place a work order to get it repaired. 10 New York Codes, Rules, and Regulations 415.14(h)