STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335628	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Adult Care Center	256 Sunset Lake Road Liberty, NY 12754

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 9/22/24 to 9/27/24, the facility did not ensure that the residents had a right to a safe, clean, comfortable, and homelike environment, including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 2 (Resident #34 and #110) of 5 residents reviewed for Environment. Specifically, the ceiling in room [ROOM NUMBER] on Unit 2 where Residents #34 and #110 resided, was observed with a large hole in the ceiling, a basin on the floor that was collecting water, with a bed pad underneath. The findings are: The undated facility policy titled Maintenance Work Order Policy documented that the Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. On 09/22/24 at 06:21 PM, the ceiling in room [ROOM NUMBER] on unit 2 was observed with a big hole in the ceiling that was approximately 2.5 feet by 2 feet and there was a basin on the floor, on top of a bed pad collecting water. Resident #34 stated that a few days ago, the ceiling fell and water was leaking everywhere. On 09/23/24 at 11:59 AM, Resident #34 was observed in room [ROOM NUMBER]-D on unit 2 and stated that their previous room [ROOM NUMBER] was a mess and they had to be moved to another room(163) and was very upset due to the move. On 09/23/24 at 02:11 PM, Resident #110 was observed in room [ROOM NUMBER]-D and stated that they wanted to leave, and was not happy, and did not like the room change, because it is cold, and the window was dirty with cobwebs. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 10:22 AM, the Director of Maintenance stated that the ceiling in room [ROOM NUMBER] unit 2, leaked causing a large hole due to the air conditioner unit above on unit 4 leaking into the ceiling. The Director of Maintenance stated that when the air conditioner unit fills up and gets dirty, it gets debris in there and then the water has nowhere to go but pool over. The Director of Maintenance stated that they were not made aware that the ceiling caved in until Monday morning (9/23/24), and the nurse did notify the maintenance assistant on 9/21/24 via verbal and in the work log, and the ceiling was not repaired until 9/23/24. The Director of Maintenance stated that there was potential for the ceiling to cave in more if the tiles got more soaked and stated that Residents #34 and #110 should have been moved for safety. The Director of Maintenance stated that they repaired it on Monday and that there was no reason why the resident's could not go back to their room. During an interview on 09/26/24 at 10:50 AM, the Director of Nursing stated that Licensed Practical Nurse #13 notified Maintenance Assistant #26 on 9/21/23 during the evening shift and put it in the maintenance communication log on 9/21/23. The Director of Nursing stated that they were made aware by nursing Maintenance Assistant #26 came put the pad and bucket in the room on the floor. The Director of Nursing stated that the residents should have been moved out of the room immediately for safety concerns and that the nursing supervisor could have made that decision. During an interview on 09/26/24 at 11:36 AM, Registered Nurse Unit Manager #18 stated that on Saturday(9/21/23) they were the supervisor on duty and did rounds on unit 2 and no one said anything about the ceiling caving in, in room [ROOM NUMBER]. Registered Nurse Unit Manager #18 stated that they were not informed until Sunday (9/22/23) during the evening shift and moved the residents from 163 to 169 for safety due to the large hole in the ceiling that was leaking water onto the floor. During an interview on 09/26/24 at 12:02 PM, Maintenance Assistant #26 stated that they were made aware about hole in ceiling in room [ROOM NUMBER] on Saturday afternoon(9/21/24). Maintenance Assistant #26 stated that they turned off the air conditioners on 2nd floor and waited for drip to stop. Maintenance Assistant #26 stated that would have replaced the tile, but it was pointless to do so while its dripping. Maintenance Assistant #26 stated that Residents #34 and #110 should have been moved for safety due to the water leaking on the floor and did notify the nurse that the tile would not have been replaced until Monday(9/23/24). 10NYCRR 415.5(i)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40686 Based on observation, interview, and record review conducted during the recertification and complaint (NY00335402) survey from 9/22/2024 to 9/27/2024, the facility did not ensure that all alleged violations involving misappropriation of resident property were reported to the New York State Department of Health. This was evident for 1 (Resident #49) of 3 residents reviewed for abuse. Specifically, the facility did not report an allegation that Resident #49's gold necklace was removed by a staff member and never returned to the resident. The findings are: The facility policy titled Resident Abuse dated 6/2023 documented any report of abuse will be reported in keeping with the New York State Department of Health regulations. Resident #49 was diagnosed with Parkinson's disease and cerebral infarction. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #49 was moderately cognitively impaired. A facility Investigation initiated 2/20/2024 documented Resident #49 and their designated representative reported that Resident #49's gold necklace went missing after 2 unidentified male staff members took the necklace for cleaning. Police were called on 3/18/2024 and a larceny investigation was initiated. There was no documented evidence the facility reported Resident #49's allegation of misappropriation of property on 2/3/2024 to the New York State Department of Health. The Administrator was interviewed on 9/27/2024 at 3:00 PM and stated Resident #49's report of a missing gold necklace was not reported to the New York State Department of Health because it was reported as a missing item and was not considered a reportable event. 10 NYCRR 415.4(b)(2)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review, and interview conducted during the Recertification and Abbreviated Surveys (NY00333577 and NY00320085) from [DATE] to [DATE], the facility did not ensure that the residents environment remained as free of accident hazards as possible for 2 (Residents #219 and #95) of 7 residents reviewed for accidents. Specifically, 1. Resident #219 who- was being transferred via Mechanical lift by two certified nurse aides, fell from the mechanical lift due to the battery dying and Certified Nurse Aides #20 and #23 unhooking the straps instead of using the emergency lower button, subsequently causing a hematoma (large pool of blood under the skin resulting from injury) to the back of Resident #219's head which resulted in them having to be transferred to the emergency room for further evaluation. 2. Resident #95 was provided with a snack upon request, which was not according to the resident's prescribed diet order. As a result, the Resident #95 sustained a choking occurrence, became unresponsive, with initiation of a full Code Blue, and was eventually transferred to the hospital. This resulted in actual harm to Residents #'s 219 & #95 that was not immediate jeopardy. The findings are: The facility policy titled Accident/Incident dated ,d+[DATE] and last revised on ,d+[DATE] documented to ensure resident health and safety. 1. Resident #219 was admitted with diagnoses including below the knee amputation to both legs, chronic pain syndrome, and dementia. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #219 had moderate intact cognition and was dependent with toileting and transfers. The [DATE] Falls Care Plan documented Resident #219 is at risk for Falls as evidenced by deconditioning, incontinence, high risk meds, and history of falls. Interventions included educating the resident/family/caregivers about safety reminders and what to do if a fall occurs. The [DATE] Accident and Incident form documented Resident #219's wheelchair tipped backwards, during a transfer from bed to chair via a mechanical lift when the battery died resulting in the resident falling on the floor. Resident #219 sustained a large hematoma to the posterior scalp (back of head) subsequently causing them to be transferred to the emergency room for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The [DATE] Investigative Summary documented Resident #219 was sent to the Emergency Department for evaluation after sustaining a fall during a mechanical lift transfer and hitting their head. Resident #219 sustained a minor injury to the back of their head after falling during the transfer. Resident #219 returned to the facility, and abuse, neglect and mistreatment was ruled out. There was immediate re-education at the point of care provided to the certified nurse aides involved. The education included both verbal and demonstration of proper mechanical lift use. Further education was then provided, facility wide. During the following week, audits were conducted to ensure proper mechanical lift use among staff and checking for charging of the battery, with competencies to be completed by staff. Resident #219 was placed on safety and neuro checks per facility policy after returning from the emergency department. The [DATE] Nursing Home Facility Incident Report submitted to the New York State Department of Health documented Resident #219 was being transferred from the bed to the wheelchair with 2 Certified Nurse Aides assistance via a mechanical lift, and per the Certified Nurse Aide statements, the mechanical lift malfunctioned, and upon further investigation and interviews, it was concluded there was also user error during the transfer. The [DATE] Nursing Progress note by Registered Nurse Supervisor #18 at 11:35 PM documented upon arrival to Resident #219's room, the resident was observed lying on their back in a wheelchair, with the lower portion of the mechanical lift pad still connected to the mechanical lift. The Certified Nurse Aides reported during transfer, the mechanical lift malfunctioned, resulting in the resident falling during transfer. Resident #219 was assessed and there was a large hematoma noted to their posterior scalp. Resident denied loss of consciousness, awake, alert answering questions appropriately, complaint of blurring/double vision and back pain but stated he had 3 herniated disks. The resident was transferred to the Emergency Department for evaluation. Review of the emergency room After visit summary dated [DATE] documented Resident #219 had a head injury with a diagnosis of falling from a height of greater than 3 feet. On [DATE] at 11:15 AM, during an observation of Unit 2 there were 4 operable mechanical lift batteries observed in the clean utility room. During an interview on [DATE] at 11:19 AM, Certified Nurse Aide #19 stated if the mechanical lift is dead, it will make a beeping noise and struggle to go up. Certified Nurse Aide #19 stated after the mechanical lift is finished being used, the battery should be placed on the charger. During an interview on [DATE] at 12:30 PM, Certified Nurse Aide #20 stated when they were lowering the resident to the chair, the battery died , and they unhooked the mechanical lift straps, resulting in Resident #219 tilting backwards in the wheelchair and falling, hitting the back of their head on the floor. Certified Nurse Aide #20 stated they did not know the battery was dead and should have checked before taking Resident #219 out of bed. Certified Nurse Aide #20 stated they should have checked the battery prior to transferring the resident and was aware the mechanical lift had an emergency button to lower the resident if the battery died . During an interview on [DATE] at 9:35 AM, the Director of Nursing stated although, the certified nurse aides should not have operated the mechanical lift with a dead battery, causing Resident #219 to fall and hit their head, there was no negligence deemed on the certified nurse aides part. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 9:45 AM, the Administrator stated safe patient handling listed on the competencies included knowledge of the mechanical lift and that Certified Nurse Aide #20 and Certified Nurse Aide #23 were trained in operation of a mechanical lift. During an interview on [DATE] at 10:52 AM, the Director of Nursing stated prior to Resident #219 falling out of the mechanical lift on [DATE], the certified nurse aides were aware of the emergency lower button on the mechanical lift. The Director of Nursing stated it was the responsibility of the night shift to charge the mechanical lift batteries. During an interview on [DATE] at 11:30 AM, the Director of Medical stated Resident #219's fall from the mechanical lift on [DATE] was considered significant and the resident was sent to the emergency department for further evaluation, and to rule out significant trauma. 10 NYCRR 415.12 (h)(1) 49255 2. The Policy and Procedure titled Certified Nurse Aide Shift Routine with purpose to ensure compliance with resident care and policies revised on ,d+[DATE] documented residents are fed according to care plan. The Policy and Procedure titled Food and Nutrition Services revised on ,d+[DATE], and edited on [DATE] documented the multidisciplinary staff, including nursing staff, the attending physician, and the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. A resident-centered diet and nutrition plan will be based on this assessment. Resident #95 was admitted with diagnoses including but not limited to non-Alzheimer's dementia, adult failure to thrive, and psychotic disorder. The [DATE] care plan documented the resident required interventions which included, but were not limited to, partial/moderate assistance with eating. Speech Therapy note dated [DATE] documented swallow evaluation was completed. The resident tolerated thin liquids and puree, liquids upgraded, no straws. Review of physician orders on [DATE] documented regular diet puree texture, thin consistency, no straws. The [DATE] care plan documented the resident required interventions which included, but were not limited to, diet as ordered: regular diet, pureed texture, thin consistency. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The [DATE] Admission Minimum Data Set Assessment (a resident assessment tool) documented Resident #95 had severe cognitive impairment, needed supervision with eating, and substantial assistance with self-care. Resident #95 had a swallowing disorder evidenced by loss of liquids/solids from mouth when eating or drinking, holding food in mouth/cheeks or residual food in mouth after meals, coughing or choking during meals or when swallowing medications, complaints of difficulty or pain with swallowing. With nutritional approaches: mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids). A facility Investigation Report signed by the Director of Nursing documented on [DATE] at approximately 8:00 PM Resident #95 requested a peanut butter and jelly sandwich from Certified Nurse Aide #7. The resident was given a sandwich upon request, the resident was at the nurse's station eating the sandwich when they began to cough. The resident was noted to be unresponsive, Code Blue called, Emergency Medical Services called, Heimlich maneuver (first aide, abdominal thrusts for someone choking) performed, the resident was suctioned, and oxygen was provided. The resident was transferred to the emergency room for an evaluation. Based on investigation, the resident's diet order was noted to be pureed. Based on interviews with staff and Certified Nurse Aide #7, who gave the resident the sandwich, Certified Nurse Aide #7 did not check the resident's diet prior to giving the resident the sandwich. Patient Review Instrument from the hospital documented the resident was admitted to the hospital on [DATE] with diagnosis including respiratory arrest associated with feeding. The Employee Statement signed by Certified Nurse Aide #7 on [DATE] documented the resident told them they were hungry and asked to have a peanut butter and jelly sandwich. Certified Nurse Aide #7 stated they got the sandwich, cut all around it and gave the resident a small piece from the middle. The resident ate it, got up, walked, and started choking. During the interview on [DATE] at 5:02 PM Certified Nursing Aide #12 stated every resident on the unit had a different diet, and they checked the tray ticket to make sure they received the right diet. If a resident had changes in their diet, the nurse would give an update or a report at the beginning or at the end of the shift. They said they also knew the electronic medical record had a fluid and nutrition section they could see the diet. If the resident asked them to have something to eat, they provided the resident with a snack depending on their diet. Certified Nursing Aide #12 said for the consistency of the food they check the list on the unit refrigerator at the nursing station, which was constantly updated. They said they received in-service education how to follow the diet upon hiring in [DATE]. During the interview on [DATE] at 5:10 PM Licensed Practical Nurse #13 stated for any residents who were on a pureed diet and requested snacks, they could provide chocolate pudding or yogurt. They said that Resident #95 had a puree diet, with thin liquids. Licensed Practical Nurse #13 said the resident did not have teeth and refused to get dentures and refused to have a dentist appointment. Licensed Practical Nurse #13 showed a list of the residents and the information with type of diets for them posted on the refrigerator at the nurse station. 10 NYCRR 415.12 (h)(1)

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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** 40686 Based on record review and interviews conducted during the Recertification and Abbreviated surveys (NY 00351488 and NY 00335211) from 9/22/24 to 9/27/24, the facility did not ensure that there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, upon review of the staffing schedule for multiple days and on all three shifts of staffing for each floor, the facility did not provide adequate staffing to meet the needs of the residents. The findings are: The Facility assessment dated [DATE] documented Licensed Practical Nurses providing direct care and Nurses Aides were staffed based on the acuity of units or demands of unit as determined by the Clinical Administration on a fluid basis as the needs of the residents and census are ever changing. 1) The facility census on 9/22/2024 was 115 residents. On 9/27/2024, the Unit 1 census was 17 and Unit 2 census was 39. A review of actual Staffing Sheets from 9/1/2024 to 9/27/2024 documented 17 of 28 night shifts where 1 Certified Nursing Assistant was scheduled and staffed on Unit 1. There were 8 of 28 night shifts where 2 Certified Nursing Assistants were scheduled and worked on Unit 2 on the night shift. On 9/27/2024 at 7:26 AM, Unit 1 was observed with a strong smell of feces emanating from a room at the beginning of the unit and permeating throughout unit. Registered Nurse #17 was observed coming out of a room and calling to Certified Nursing Assistant #25 who was in the hallway at the soiled linen cart. Licensed Practical Nurse #26 was observed sitting at the nursing station. There were 2 of 17 total residents on the unit up and out of bed eating breakfast. There were 12 residents asleep with their breakfast trays at bedside. At 7:50 AM, Registered Nurse #17 left the unit and 2 staff members remained. The smell of feces was still apparent and observed from the Unit 1 hallway. On 9/27/2024 at 7:32 AM, Certified Nursing Assistant #25 was interviewed and stated they always worked the night shift from 12 AM to 8 AM and was usually assigned to the Unit 4. Certified Nursing Assistant #25 was asked to cover the shift on Unit 1 because the facility was short of staff. Registered Nurse #17 was the Nursing Supervisor and helped with providing residents with care because the Licensed Practical Nurse was responsible for medication pass and wound treatments. The night shift was hectic because Certified Nursing Assistant #25 was usually assigned to 20 residents and had to begin getting residents up at 5 AM for breakfast at 6:15 AM. Some residents complained about getting up early and were allowed to sleep in. Most of the residents agreed to eat breakfast. There were approximately 3 residents on Unit 1 that requested not to be assigned to a male aide and the charge nurse did assist in providing those residents' care. The same aide kept calling out or not showing up which created a staffing shortage. Domestic Aides were used by the facility on the day and evening shifts to escort residents to appointments, make beds, or restock the units. The Domestic Aides did not assist with or provide activity of daily living care to residents. There were no Domestic Aides assigned to the night shift. Certified Nursing Assistant #25 stated they found their assignment overwhelming at times when they had several residents that required more assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/2024 at 7:48 AM, Registered Nurse #17 was interviewed and stated they worked as the Nursing Supervisor on the night shift for the facility for approximately 1 year. The staffing ratio was 1 Certified Nursing Assistant to 15 residents. There was a mistake on the schedule so 1 Certified Nursing Assistant was placed on Unit 1 and Registered Nurse #17 helped the aides. During the interview, Registered Nurse #17 referenced a printed email from the Director of Nursing dated 9/10/2024 that was hanging from a bulletin board in the nursing office and stated, the Nursing Supervisors were informed Unit 1 was overstaffed and should only be assigned 1 Certified Nursing Assistant for the night shift. The staffing par levels were 1 aide for Unit 1 and 3 aides each on Unit 2, Unit 3, and Unit 4. The night shift that just ended had 1 aide on Unit 1, 2 aides on Unit 2, and 3 aides each on Unit 3 and 4. Unit 1 was considered the subacute rehab unit for beds 100 to 110 and the rest of the unit was for residents on palliative care. Registered Nurse #17 stated their shift began at 8 PM and they were usually dealing with staffing issues. There was at least one callout daily and there was one staff member that consistently called out every time they were on schedule. There were also times the schedule had mistaken where someone was scheduled but did not know they were scheduled or were on vacation. Callouts were the biggest issue. Certified Nursing Assistant #27 was mistakenly scheduled to work Unit 1 on the 9/27/2024 night shift but was on a rotating weekend schedule and was supposed to be off so they should have never been placed on the schedule. There were also times the facility would schedule an agency aide for a double shift and after working 1 shift, the aide would cancel their second shift and leave the facility short of staff. Another Licensed Practical Nurse did not work a full shift on Unit 1 and left early leaving Licensed Practical Nurse #26 as the only nurse on Unit 1. Night shift staffing became a problem during breakfast time at 6 AM. There were less staff scheduled for the night shift and the staff were expected to have residents up and fed for the breakfast meal. Registered Nurse #17 pointed to the schedule and stated the empty slots on the page were slots for staff that should have been scheduled but had not been filled. The problem with staffing was on the night shift because of the breakfast meal. Registered Nurse #17 stated they were also responsible for fielding callouts and assisting with staffing for the upcoming day shift. On 9/27/2024 at 8:40 AM, Licensed Practical Nurse #8, was interviewed and stated they were concerned with agency staff that were assigned to cover their unit on their days off that were not properly trained in the charge nurse responsibilities. They had email communications with the Director of Nursing that started in January 2024 but stopped in March 2024 after the Director of Nursing told Licensed Practical Nurse #8 to stop complaining about staffing. There were times that aides disappeared for several hours without repercussion. Licensed Practical Nurse #8 stated they had issues with looking for supplies on other units and was unable to find staff. There was no oversight or supervision of staff on the night shift. Licensed Practical Nurse #8 had to assist with feeding breakfast to residents on their shift and there were times that they were still feeding residents until 7:45 AM. Staff burnout occurred because the assignments were not rotated, and some aides complained that their assignment was heavier. The facility Administration made room changes to accommodate staff complaints regarding their assignments instead of rotating staff. Recently, the get-up schedule of residents that the night shift were required to have out of bed for breakfast and before the day shift arrived, changed and residents were added to the list, placing more responsibility and work on the night shift. On 09/27/24 at 9:34 AM, Licensed Practical Nurse # 4 was interviewed and stated they worked overtime for the facility 1-2 two times per week. Licensed Practical Nurse # 4 stated they covered three 12-hour shifts and two 8-hour shifts per week. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/27/24 at 9:37 AM, Registered Nurse Unit Manager #5 was interviewed and stated, on average the direct care staff were short staffed usually 1-2 times per week. However, the facility was very short staffed and did not have enough staff to care for the residents. On 09/27/2024 at 11:16 AM, the Staffing Coordinator was interviewed and stated the staffing schedule was created on 2-week cycles and was a collaboration between the Administrator, the Staffing Coordinator, and the Director of Nursing. There was a meeting held every Thursday to discuss staffing schedule needs and changes. Staffing par levels changed according to unit census. If there were more than 15 residents on Unit 1, there should be 2 Certified Nursing Assistants. The Administrator and/or Director of Nursing dictated whether units were overstaffed. The evening 4 PM to 12 AM and night 12 AM to 8 AM shifts were very challenging to staff. The facility was unable to find staff that wanted to work those shifts. Callouts and other staffing issues were considered when making the schedule. The Staffing Coordinator stated they were continually working to cover the blank slots on the schedules. If the slots were not filled, staff were asked to work double shifts or stay over. The Staffing Coordinator worked with 3 separate staffing agencies but there were no-calls, no-shows. Agency staff were given 3 chances to show up and, if they did not show, the Staffing Coordinator took them off the schedule. Agency staff were booked for more than one shift before the facility confirmed they were reliable. There were limitations in asking certain regular staff to work double shifts because of their contract. The Director of Nursing determined 1 Certified Nursing Assistant was acceptable on Unit 1 because the facility had staffing issues. There were staffing issues identified on the previous recertification survey and the facility attempted to attract more staff with flexible hours, higher wages, hiring staffing agencies, and other incentives. Domestic Aides were used on the day and evening shifts to assist with filling water pitchers, making beds, and as escorts to outside clinic appointments. On 09/27/2024 at 03:27 PM, the Administrator was interviewed and stated the facility made efforts to improve staffing since the last recertification survey, conducted job fairs, and put a process in place to get in touch with job candidates faster. There were also pickup shift bonuses, sign on bonuses, additional staffing agencies brought on board, and flexible hours given to staff to obtain and retain staff. Hiring and new employee orientation have been improved with the new inservice coordinator. The facility par levels were in line with the New York State Department of Health staffing par levels of 3.5 nursing hours per resident per day. Unit 1 should have 2 aides if they have a census of 20 residents. Acuity level was part of the staffing discussion during the weekly staffing meetings. Unit 1 currently had a census of 17 residents and only required 1 aide to be scheduled on the night shift. Unit 2, the locked Dementia Unit, should be staffed with 2 to 3 Certified Nursing Assistants at night. The Administrator stated they were aware that a meal service was scheduled on the night shift and that there had been discussions regarding how this effects staff and residents. The Licensed Practical Nurse and Registered Nurse Supervisor helped with providing activity of daily living care to residents. It was more difficult to staff the night shift. The Administrator stated they were more concerned with staffing the evening shift and stated agency staff were used to pick up shifts on a regular basis. 10 NYCRR415.13(a)(1) (i-iii) 49364