STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335631	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapin Home for the Aging	165 01 Chapin Parkway Jamaica, NY 11432

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observations, record review, and staff interviews during the Recertification survey between 09/03/2024 and 09/10/2024, the facility did not ensure that needed services, care and equipment are provided to assure that resident with limited range of motion and mobility maintain or improve function based on the residents' clinical condition. Specifically, a resident with an order to apply shrinker to left knee was observed with no device as per Physician's order. This was evident for 1 resident reviewed for Limited Range of Motion, (Resident #96) out of 32 sampled residents, The findings are: The facility's Policy and Procedure for .Equipment/Devices and Nursing Rehab Program dated 08/2014, documented: .Upon assessment, the Rehab team will provide recommendations for necessary skilled therapy, maintenance program (via Nursing Program), and for any equipment and or/devices the resident may require at that time. Resident #96 was admitted to the facility with diagnoses that included: Hypertension; Asthma, Chronic Obstructive Pulmonary Disease; Cataracts, Glaucoma, or Macular Degeneration. The Annual Minimum Data Set, dated dated dated [DATE] documented the resident has moderate impairment in cognition and is total dependence of staff for most activities of daily living. The Comprehensive Care Plan for Activities of Daily Living Functional Status/Rehabilitation Potential dated 07/23/2021, last reviewed 06/26/2024 documented, that Resident has gait dysfunction, impaired balance, weakness, and decrease in range of motion. Goals are to maintain current functional status, prevent decline and contracture. Interventions included Active Range of Motion to both upper extremities and passive range of motion to both lower extremities. Left knee shrinker to be worn at all times. Remove for hygiene and skin check. There is no documented evidence in Resident #96 Comprehensive Care Plan updated as at 06/26/2024 that the resident is refusing to wear the shrinker or any device ordered for the resident. Physician's Order dated 09/10/2021 documented Rehab: Left knee shrinker to be worn at all times remove for hygiene and skin check. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/03/24 at 10:41 AM, Resident #96 was observed in bed, alert and oriented and noted with a below left knee amputation. Resident was interviewed and stated that the staff are not applying anything on their left stump. Resident also stated that the staff were applying some dressing on the right foot before, but they are no longer applying the dressing and they don't know why. Between 09/03/24 and 09/09/24, Resident #96 was observed in bed daily. There was no device applied to the resident's left stump, and there was no device observed in the resident's room. On 09/09/24 at 10:10 AM, an interview was conducted with the Certified Nursing Assistant #1. Certified Nursing Assistant #1 stated that they have been working in the facility for [AGE] years and has been taking care of Resident #96 since after the COVID-19 outbreak. Certified Nursing Assistant #1 also stated that resident is washed, changed, and given a bed bath every day because resident refuses to take showers. They also refusing to come out of bed. Certified Nursing Assistant #1 further stated that resident has a booty applied to the left leg heel all the times but has no device on the left stump because it is amputated. Certified Nursing Assistant #1 stated that they are not aware of any other device to be applied to the left leg apart from the prosthesis that is given to the resident when out of bed. On 09/09/24 at 11:10 AM, Licensed Practical Nurse #1 was interviewed and stated that Resident #96 is provided with a booty on right leg all the time, which resident sometimes refuses. Resident will ask the staff to come back later to apply the booty. Licensed Practical Nurse #1 stated that Resident does not have any device on the left leg anymore. Licensed Practical Nurse #1 stated that resident was having something like stocking on the left stump before, but they have not been seen the device anymore and they could not recollect the last time they saw Resident #96 with the left stump device. On 09/09/24 at 11:48 AM, an interview was conducted with the Assistant Director of Nursing who, stated that Resident #96 has order for the heel booty for the right leg, the left leg is amputated, and has an order to have left shrinker all the time. Assistant Director of Nursing stated that they have not seen the resident with the shrinker, and they don't know why they have not been putting it on the resident. Assistant Director of Nursing further stated that they will have to follow up with the Rehab department because Physical Therapy/Occupational Therapy are supposed to provide the device. On 09/09/24 at 12:08 PM an interview was conducted with the Director of Physical Therapy, stated that: Resident #96 is on range of motion program done by nursing - supposed to be twice daily, has the prosthesis when first admitted , but has been declining and has stiffness on the right knee. The left leg is amputated, within functional limit, has an order for the shrinker to be applied to the stump at all times, remove for skin check by nursing. Physical Therapist Director stated that when they screened the resident, they make sure that all equipment and devices are there, they don't normally check regularly if resident is wearing it or not unless they are notified by nursing that resident is not having it or not wearing it. Therapist stated that rehab has not been notified that the device is missing or that resident is not using it. Rehab order recommendation by (Director of Physical Therapy dated 09/10/2021 documented Left knee shrinker to be worn at all times remove for hygiene and skin check. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 10:29 AM, the Nurse Educator was interviewed and stated that the Certified Nursing Assistants have been educated on how to check their tasks to see what devices have been ordered for the residents and how to apply them, they were also educated to notify the manager/Rehab staff if the device is missing or if resident is refusing the device; the unit nurses have also been educated to ensure that they are monitoring the Certified Nursing Assistants that they are carrying out their assigned responsibilities as per residents' plan of care. Nurse Educator stated that they are surprised that the Certified Nursing Assistant does not know that Resident #96 has the device, and they are signing for it. Nurse Educator further stated that staff have been educated several times, it is unbelievable that Certified Nursing Assistants/Nurses are still not doing things right despite the education. On 09/10/24 at 10:29 AM, an interview was conducted with the Director of Nursing. The Director of Nursing stated that Certified Nursing Assistants are trained to apply ordered devices for the residents, the devices are documented in their Care Tasks to check and carry out the task as instructed. Director of Nursing stated that Resident #96 device is being documented by the Certified Nursing Assistant that resident has been refusing it. Director of Nursing stated that they cannot explain why the staff are signing that resident is refusing when they don't know that resident has the device as per their response to interview. 10NYCRR 415.12 (e)(2).

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F 0689 Level of Harm - Minimal harm or potential for 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** 44864 Based on interviews and record review conducted during a Recertification and Complaint survey (NY00343925) from 09/03/2024 to 09/10/2024, the facility failed to ensure each resident received adequate supervision to prevent elopement. This was evident for 2 of 2 residents (Resident #139 & Resident #140) investigated for Accidents, out of an investigative sample of 32 residents. Specifically, on 05/31/2024 at 4:45 PM, (Resident #139 & Resident #140) left the facility unannounced. Video footage dated 5/31/24 revealed that Residents #139 & Resident#140 left the unit via dietary elevator ground floor at 06:17PM and exited the back door at 06:19PM. They walked to the side of the building, then out of the gate to the backyard. Resident #140 was located at their prior apartment and Resident#139 was located at a Manhattan precinct. The findings are: The facility's policy and procedure dated Elopement Protocol Response Plan Policy last 6/2/24, documented that prevention of an elopement is the facility's 1st priority, and that identifying residents at risk and monitoring their movement is especially important. Resident #140 was admitted to the facility with diagnoses that include Vascular Dementia mild with Anxiety and Alzheimer's Disease. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident's #140 cognition as severely impaired with a Brief Mental Status of 3, wandering with behavior occurring, wandering significantly intrude on the privacy or activities of others and no elopement alarm used. The Admission Minimum Data Set also documented independent with eating, bed mobility, supervision with toileting and transfers, and supervision for walking. The elopement risk assessment dated [DATE] documented Resident#140 as ambulatory or independent in wheelchair locomotion, has risk factors does not exhibit any additional elopement risk criteria, and that elopement care plan not initiated, see comments, not applicable. A Comprehensive Care Plan on Behavioral symptoms, was initiated on 4/18/24. The care plan documented that Resident#140 is at risk for elopement, packs all belongings and look for exit. The goals included resident will adjust to facility, and not elope from facility, edited 7/18/24, target date 10/9/24. The interventions include ensure resident ID band is in place every shift, monitor resident's behavior and provide diversional activities, such as social activities, games, and music. A Nurse's note dated 5/31/24 at 6.02PM, documented that Resident#140 was seen by staff around 3.45PM, and that around 4.30PM, code M was called for the said Resident #140. A search of the building was activated, the Director of Nursing and the Administrator was made aware after the initial search. A Nurse's note dated 06/01/24 at 2:30PM, documented that around 1:57AM, resident returned to the facility accompanied by 2 staff members, appears to be in good stable condition, no changes in ambulation, skin integrity and that a right ankle wander guard was initiated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's note dated 6/5/24, documented patient recently eloped, no injuries noted. Patient remains alert, no significant change in cognitive status, and caution to prevent elopement. An elopement evaluation dated 6/1/24 documented resident is ambulatory, is cognitively impaired, poor decision-making skills, makes statements that they are leaving, elopement care plan initiated, wander guard placed to ankle. Resident#139 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's Disease and Anxiety Disorder. The Admission Minimum Data Set, dated dated dated [DATE] documented that resident's cognition as severely impaired, Brief Interview of Mental Status score of 4, no wandering, no behaviors, independent with mobility, supervision with transfers and walking, and no wander/ elopement alarm. The elopement risk evaluation dated 3/21/24 documented resident is ambulatory, is cognitively impaired, poor decision-making skills, displays behavior that may indicate an attempt to leave, body language etc. and that elopement care plan initiated. The Comprehensive Care Plan titled Behavioral symptoms, initiated 3/21/24, documented resident is at risk for elopement, waits in front of the elevator. The goals included resident will adjust to the facility, target date 06/21/24. Interventions included to monitor resident's behavior and provide diversional activities encourage sitting with peers in day room. Provide comfort items offer adult coloring, staff to monitor resident via visual check throughout shift during all activities. A Nurse's note dated 05/31/24, documented that Resident #139 who has periods of forgetfulness and confusion, but alert and verbally responsive was last seen by Staff around 3.45PM. Around 4:30pm, code M was called for the said resident, searched the building was activated. The Director of Nursing and the Administrator were made aware after the initial search. A Nurse's note dated 6/1/24 documented that around 1:20AM, Resident#139 returned to facility with 2 Staff, appears in good spirits, no changes in ambulation. The facility's incident report dated 06/02/24, documented that on 05/31/24, Resident # 140 and Resident # 139 were unaccounted for by Staff at dinnertime. Staff initiated a search, called other units to inform them of the situation and then notified security. The summary also documented that Residents #139 and #140 were seen at the beginning at the shift ambulating in the hallway, however, they were not seen at dinnertime. Checks were done on the unit, and they were unable to locate both residents. The security was notified, Code Houdini was called, which is the Elopement code. All rooms, floors, and camera reviewed to determine route to egress. On 06/01/24,the New York Stated Department of Health intake report documented that the Director of Nursing reported that Residents #139 and #140 who eloped together, were found off premises by 11:30PM, and there was no harm to either resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5-day summary investigation reported to the New York Stated Department of Health dated 6/7/24, documented that New York Police Department was called and notified of the event and responded to the facility at 9:45PM. Based on the investigation, corrective action included the mezzanine unit with the Dementia residents were placed on a 30 minute visible head count x 14 days. In order to correct the systemic changes, both elevator F, G are key locked, maintenance will be installing key pads code box, to both elevators that will require Staff to key in codes. The rear administrative parking lot gates remain closed except for shift changes. A Quality Assurance Performance Improvement meeting was held on 6/3/24 and revealed that Residents' #139 and 140 elopement was discussed. Project overview involved reduction of elopement risk, remodeling of current safety interventions, unique to the residents on the Mezzanine level. The Quality Assurance Performance Improvement was reviewed and revealed that the interventions implemented for the elopment was completed on 08/15/24. On 09/05/24 at 02:11 PM, Certified Nursing Assistant #3 was interviewed and stated that they work on 2:30PM-10:30PM shift on 05/31/24. Certified Nursing Assistant #3 also stated that when they came on the unit, they do rounds. and that all the residents were accounted for at that time. Certified Nursing Assistant #3 also said that they realized that Resident #139 and Resident #140 were missing when it was time to serve the dinner, around 4:30PM and 5:00 PM, and the Staff all started looking from room to room. Certified Nursing Assistant #3 said that the staff first realized that Resident #140 was not on the unit, and then realized that Resident #139 is also missing . The Certified Nursing Assistant #3 stated that they knew Resident #139 is candidate for elopement, so they would always closely monitor the resident. Certified Nursing Assistant #3 stated that when they viewed the camera footage, they saw that the dietary elevator came up by itself, unmanned, and that both residents (Resident #139 and Resident #140) went into the elevator. Certified Nursing Assistant #3 stated that they have been in serviced on Elopement. On 09/05/24 at 02:24 PM, Certified Nursing Assistant #4, was interviewed and stated that they worked on 05/31/24 on the 2:30PM-10:30PM shift, and that they were assigned to the dining room for supervision. Certified Nursing Assistant #4 stated that on that day, both residents (Resident #139 and Resident #140) were in the dining room initially, and then Resident #139 came out 1st, then Resident #140 came out. Certified Nursing Assistant #4 stated that don't recall the time, but said that it was around dinner time, at 5:00pm, when they realized that Resident #139 and Resident #140 were missing, Certified Nursing Assistant #4 said that they started looking in all the rooms, notified the charge nurse, who informed the Registered Nurse Supervisor. An elopement code M was then called. Certified Nursing Assistant #4 said that they have been in serviced on Elopement. On 09/05/24 at 02:36 PM, Licensed Practical Nurse #2 was interviewed and stated that they are the primary Licensed Practical Nurse for the unit Mezzanine, on the 6:30AM- 2:30PM shift. Licensed Practical Nurse #2 stated that Resident #140 have always exhibited exit seeking behaviors and looking to get out. Licensed Practical Nurse #2 also stated that they did not work on 05/31/24, and that neither Residents #139 nor Resident #140 had wander guards, however, they are always supervised by Staff when they walk in the hallway. Licensed Practical Nurse #2 also stated that they have been in serviced on Elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/24 at 02:54 PM, Licensed Practical Nurse #3 was interviewed and stated that they are the primary Licensed Practical Nurse for the unit Mezzanine, on the 2:30PM- 10:30PM shift, but did not work on 5/31/24. Licensed Practical Nurse #3 stated that Resident #140 has been exhibiting exit seeking behavior since admission, and that the behavior had escalated, but had calmed down. Resident#139 would walk up and down the hallway but did not attempt to get on the elevator. Licensed Practical Nurse #2 stated that on admission, the Supervisor would do an elopement risk assessment, and the nurses would monitor the resident. Licensed Practical Nurse #3 stated they have been in serviced on Elopement. On 09/06/24 at 06:21AM, Licensed Practical Nurse #4 was interviewed and stated that they worked on 05/31/24, on the 2:30-10:30PM shift. Licensed Practical Nurse #4 stated that when they came on the unit, they saw Resident #140, just before 4:00PM. At around 4:45PM, at the start of the dinner, the staff did a head count and noticed that Resident#140 and Resident #139 were missing. The Licensed Practical Nurse#4 also stated that prior to the dinner, the residents displayed no exit seeking behaviors. The staff then checked all the rooms and adjoining areas, and when they did not locate the residents, they notified the Registered Nurse Supervisor. An elopement code was called, and the Licensed Practical Nurse #4 stated that they went outside, but the residents could not be found. Both Residents#139 and #140 did not have on any wander guards and that the dietary elevator door can only be opened by a key. Licensed Practical Nurse #4 said since it is the Dementia unit, the staff supervise them all the time. The staff now must have 30-minute monitoring for all the residents. Licensed Practical Nurse #4 said that they have been in serviced on Elopement. On 09/06/24 at 10:19 AM, the Director of Nursing was interviewed and stated that the Mezzanine unit is a unique unit for the Dementia residents, the residents are supervised and allowed to walk on the unit. Prior to the elopement of Residents #139 and Resident #140, the elevators were operated by keys, and that visitors to the units would be escorted by Staff. Staff would also use the stairwell to lessen the opening of the elevators. The Director of Nursing also stated that the dietary elevator, which is a separate elevator, on the other side of the hallway, does not open by itself, and is used mostly by dietary staff. The Director of Nursing stated that they did not know how the dietary elevator doors opened by itself, allowing Residents#139 and Resident#140 to get into the elevator, as the facility later saw when they reviewed the camera footage. The Director of Nursing stated that once the Residents #139 Resident#140 were found to be missing, the elopement code was initiated and a search, both inside and outside the facility, was initiated. The residents were later found later that night: Resident #139 was at a Police precinct in Manhattan, and Resident #140 was found at their home. The Director of Nursing stated that an elopement risk re-assessment was subsequently done on all the residents in the facility, Staff was in-serviced on elopement and an elopement drill was done. Aa Quality Assurance Performance Improvement meeting was held on 06/3/24 and a plan was discussed to prevent further elopements. The Director of Nursing also stated that the elopement risks are done on Admission, quarterly and periodically. On 09/06/24 at 10:38 AM, The Administrator was interviewed and stated that when Residents #139 and Resident#140 elopement occurred, they were not in the facility. The Administrator stated that they were notified immediately, came back to the facility, and called 911.The Administrator stated that the residents were later found in separate areas, in [NAME] and Manhattan. The Administrator stated they cannot figure out how the elevator door for the dietary elevator, opened. The Administrator stated they do not overuse the wander guard, and the facility tries not to overreact by using wander guards. The Administrator stated that security enhancements have been made in the facility. The vulnerability is monitored by the cameras, and that the outside gates are now improved. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/10/24 at 10:40 AM, the Security Supervisor of Security, was interviewed and stated that they worked on 05/31/24, and there are 2 security guards until 6:00PM. The Security Supervisor stated that they were notified by a Certified Nursing Assistant, that the 2 residents were missing. Security Supervisor stated that they called the code for missing residents, they organized and handled the whole operation at that time for the elopement. The Security Supervisor stated that a lot of changes have been made since that time of the elopement, and that prior to the elopement, they (security) would have heard just a chime, and seen the camera, but the gates are back gates to the parking lot are not kept open anymore, and are opened only when a car comes in. The Security Supervisor also said that at that time of the Residents' exit on 05/31/24, they were not in front of the cameras, and that there was another security guard, who was busy with an event that was being held, but the Security Supervisor was in the charge of the elopement protocol. On 09/10/24 01:18 PM the Administrator was interviewed and stated that they were aware that there was another security guard, who was involved in the search and that the security was aware of the elopement. The Administrator stated that they did not know if the security guard submitted a statement and or was interviewed. The Administrator stated that the security guard has since left due to illness. The facility implemented corrective actions and was found to be in substantial compliance on 08/15/2024, prior to the start of the Recertification Survey on 09/03/2024. Resident #140 was located at their prior home and returned to the facility on [DATE] at around 1:57AM, accompanied by 2 staff, without injury. Resident #139 was located at a Manhattan Police precinct and returned to the facility on [DATE] at around 1:57AM, accompanied by 2 staff, without injury. Immediately after event on 06/01/24, all residents were reassessed for elopement risk. An elopement risk assessment done on 6/1/24, documented Resident#140 as ambulatory or independent in wheelchair locomotion, has risk factors exhibits additional elopement risk criteria, and that elopement care plan was initiated. A Comprehensive Care plan for Elopement for Resident #140 was initiated on 06/01/24. The Comprehensive Care plan for Elopement for Resident #139 was updated on 06/01/24. The Elopement prevention policy dated 6/20/24 was reviewed and updated. All residents on the mezzanine unit were placed on 30-minute rounds monitoring. A facility wide in-service on Elopement and Elopement Drills were initiated on 05/31/24 and completed on 08/30/24. Residents#139 and #140 were seen by their primary medical doctor. As of 8/15/24, on the Mezzanine unit, all residents remain on 30-minute monitoring round by staff and documentation will be done daily on the residents' activities, behavior, and care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Dietary staff will continue to enter the elevator code to deliver food trays. A new keypad was implemented to alert keypad to stop the elevator from closing when a resident with a wander guard gets on the elevator. This code is also to access the mezzanine. All staff have been in-serviced with the code. The keypads have been placed in the elevators and outside the elevator on the mezzanine. The same code is required to exit the unit. All staff have been in-serviced to use stairwell B to access the mezzanine units as well to minimize the elevator opening. Visitors to the mezzanine are scheduled and escorted by staff who input the code to access the elevator, prior to pushing the call button for mezzanines. The outside gate automation was activated on 08/08/24. On 8/8/24, the rear gate reconstruction was completed, and the gate activated. The rear gate requires an intercom and keypad, to allow access to the rear parking lot. Once any vehicle has exited the parking lot, the gate will automatically close behind the vehicle, triggered by sensors. On 08/14/24 door upgrades have been completed and implemented by a service company. The activities door, the first floor A stairwell, the mezzanine B stairwell, the ground floor C & D stairwells and the ground floor delivery entrance, now have perimeter mode mag locks and anti-tailgate with a 15 second emergency release. All additional doors have a bypass keypad that requires a code to open the door for 10 seconds. The delivery entrance will continue to let the staff exit to the rear parking lot, by touching the crash bar. Exit doors A, B, C, D have passive locking systems which will require the crash bar to be pushed for 15 seconds. The front desk staff could monitor all exit doors with the wander guard system. 415.12(h)(2)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50820 Based on observation, record review and interviews conducted during the Recertification Survey from 09/03/2024- 09/10/2024, the facility did not ensure that Nurse Staffing was posted appropriately. Specifically, the posting of daily nurse staffing information was not posted in a prominent area which was readily accessible to residents and visitors. The findings are: The facility policy and procedure titled Nurse Staffing Coverage Plan dated 9/11/2009 and last revised on 5/16/2024 documents; daily nursing schedules will be posted on the nursing supervisor door along with daily nursing data sheet which is readily accessible to residents, visitors and staff. During observations conducted on 09/03/2024at 9:05AM, 09/04/2024 at 9:10AM, 09/05/2024 at 2:15PM, and 09/06/2024 at 9:00AM, the postings of the daily nurse staffing levels for each shift could not be located nor any signage instructing residents or visitors where it was located. On 09/06/2024 at 3:14 PM, the State Surveyor asked the Staffing Coordinator where the staffing information was located and was shown the posting located in front of the first-floor supervisor's office door in a hallway. This area was not readily accessible to residents or visitors. On 09/06/2024 at 3:16 PM, the Staffing Coordinator was interviewed and stated that the staffing roster and data sheet has always been placed in front of the supervisor's door. The Staffing Coordinator stated they were not aware it had to be posted in visible area for all staff, residents and visitors to see. The Staffing Coordinator stated that moving forward it will be posted in a more visible area. On 09/09/2024 at 02:48 PM, The Director of Nursing Services was interviewed and stated that the staffing schedule has always been in front of the supervisor's door on the first floor for many years. Usually, it was a place where residents and visitors passed through. However, during COVID, the set up had to be changed within the facility and this may have impacted the places where residents and visitors walk through currently in the facility. 10 NYCRR 415.13