STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335644	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kings Harbor Multicare Center	2000 E Gunhill Road Bronx, NY 10469

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the survey the facility failed to ensure that a resident was free from physical restraints for purposes of discipline or convenience and that are not required to treat the resident's medical symptom. This was evident for one (1) of two (2) residents (Resident #642) reviewed for Physical Restraints out of 39 total sampled residents. Specifically, Resident #642 was observed, on multiple occasions, in bed with two (2) upper half side rails raised on both sides. The siderail assessments were incomplete, the physician order documented use of a one (1) half side rail as an enabler, there was no documentation of the medical necessity for use of the side rails, and Resident #642 was not able to lower the bed rails voluntarily.The findings include:The facility policy titled Side Rails, last reviewed on 06/2025, stated that it is the policy of the facility to provide residents with side rails in a manner that promotes resident safety and dignity based on individual patient assessments and clinical judgement. The policy also states side rails will be provided to residents as an enabler to assist with bed mobility and will be monitored for safety and prevention of entrapment. The policy further stated residents will be assessed for use of side rails on admission, readmission, quarterly, and when there is a change in the resident's condition. The policy stated a medical order will be obtained for residents who require side rails and has informed consent, will include the type of side rail and use as an enabler. The policy also stated that the resident or resident representative will be provided with education regarding the use of side rails to assist with bed mobility and informed consent will be obtained prior to use.The facility policy titled Physical Restraints, last revised 10/2021, stated it is the policy of the facility that all residents have the right to be free from any physical restraints imposed for purposes of discipline or convenience and not required to treat the residents' physical symptoms. The policy also stated upon admission/readmission the resident will be assessed for the need for a physical restraint, and all residents with restraints are to be evaluated at least quarterly by the Comprehensive Care Plan Team Members for need of continued use (more often if the resident's condition warrants). The policy further stated physical restraint use will be initiated after a medical order has been obtained for a specific type of restraint and the medical symptoms requiring its use. In addition, the policy stated that prior to the application of a restraint, written acknowledgement must be obtained from the resident or designated representative to include discussion of benefits and risks. Resident #642 was admitted to the facility with diagnoses including stroke with paralysis (loss of ability to move part of the body) of the right dominant side and Non-Alzheimer's dementia.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #642 was severely cognitively impaired, had limitations in range of motion on both sides of the upper and lower extremities and required dependent assistance of staff with transfer, bed mobility and bathing, and bed rails were not in use in bed.On 03/30/2026 at 11:20 AM, Resident #642's bed was observed with two (2) upper side rails attached that were lowered and Resident #642 was not in the bed. On 04/01/2026 at 9:19 AM, Resident #642 was observed in bed sleeping. Two (2) upper side rails were raised. On 04/02/2026 at 12:30 PM, Resident #642 was observed in bed alert, lying on their left side. Two (2) upper side rails were raised. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2026 at 2:25 PM, Resident #642 was observed in bed. Two (2) upper-enabler side rails were raised. Licensed Practical Nurse #11 asked Resident #642 to hold on to the rails while being turned and Resident #642 was able to follow the instruction. Registered Nurse #13 then asked Resident #642 to lower the side rails, but they were not able to do so. Siderail Use Assessments completed on 08/29/2025 and 09/15/2025 documented Resident #642 was able to follow commands, required assistance with bed mobility and was using the side rail for positioning and support. The Siderail Use Assessment also revealed the side rail recommendations was incomplete, and sideral location was documented as bilateral (both sides). Siderail Use Assessments completed on 10/20/2025 and 12/10/2025 documented Resident #642 was able to follow commands, required assistance with bed mobility and was using the side rail for positioning and support. The Siderail Use Assessment also revealed the side rail recommendations documented siderails indicated and serve as an enabler to promote independence, and side rail location was documented as bilateral (both sides). A Siderail Use assessment dated [DATE] documented Resident #642 was able to follow commands, required assistance with bed mobility and was using the side rail for positioning and support. The Siderail Use Assessment also documented the side rail recommendations was incomplete, and side rail location was documented as bilateral (both sides). A Physician Order initiated 11/14/2025 and renewed 03/14/2026 documented the use of one (1) half side rail as enabler. The Care Plan Activity Report with focus Non Restraint Wheelchair Seatbelt/Siderails effective 08/29/2025 and updated 02/12/2026 documented that Resident #642 was provided with two halves side rails as enabler and Resident #642's current bed mobility is dependent of two (2) for bed scooting, extensive assistance of two (2) for bed rolling, and transfer status is total assistance of two (2) via Hoyer lift.The Care Plan Activity Report with focus Fall documented that on 8/23/2025 at 8:50 PM, Resident # 642 was observed on the floor by unit Licensed Practical Nurse. Resident was observed lying on the floor, to the right side of the bed on their left side in a fetal position with back toward the air conditioner and head toward the top of the bed. Wheelchair was in locked potion at the foot of the bed. The note also sated Resident #264 was assessed on the floor and had swelling to the left side of their forehead and blood coming from their mouth with a slight cut to their lip. The note further documented that upon interview Resident #642 was unable to give an account of incident due to severe impairment in cognition. The Care Plan Activity Report with focus Fall documented that on 9/06/2025 at 11:54 PM, Resident #642 was observed on the floor, and was unable to state what happened due to cognitive impairment. Resident #642 complained of pain to left hip, and there was mild bleeding to inner upper lip and was evaluated at the hospital.Siderail Use Assessments completed on 08/29/2025 and 09/15/2025 documented Resident #642 was able to follow commands, required assistance with bed mobility and was using the side rail for positioning and support. The Siderail Use Assessment also documented Resident/Family did not consent to the use of side rails as enablers, the side rail recommendations was incomplete, and sideral location was documented as bilateral (both sides). There was no documented evidence that a medical symptom that requires the use of bed rails was identified for Resident #642, and there was no Physician's order for the use of two (2) upper side rails. On 04/03/2026 at 8:34 AM, an interview was conducted with Certified Nursing Assistant #14 who stated Resident #642 has two (2) upper side rails in place to hold onto while they are providing care. Certified Nursing Assistant #14 also stated the side rails support Resident #2 during turning and positioning when they are instructed to hold on. Certified Nursing Assistant #14 further stated they have observed Resident #642 lying on their side holding on to the side rail. Certified Nursing assistant #14 stated the side rails may prevent the resident from falling when they move in bed in a scooting position, but Resident #642 was found on the floor near the bed, and the side rails did not keep Resident #642 from falling. On 04/03/2026 at 8:50 AM, an interview was conducted with Licensed Practical Nurse #10 who stated that side rails are used to transfer residents from the wheelchair to the bed by instructing the resident to hold on to the device so they can pivot to sit on the bed and can also help with positioning residents in bed. Licensed Practical Nurse #10 also stated Resident #642 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requires two (2) persons to transfer them with the Hoyer lift as they cannot stand and pivot, so in their case the side rails helps them to turn and helps them to stay on their side while care is being provided. Licensed Practical Nurse #10 further stated that there is a risk that the Resident #642's fingers or face can get stuck or caught in the side rail , so they try to keep Resident #642 in the middle of the bed with wedges, but they still move. Licensed Practical Nurse #10 stated that Resident #642 had an unwitnessed fall out of bed once with the side rails in place. On 04/06/2026 at 12:41 PM, an interview was conducted with Registered Nurse #12 who stated that Resident #642 cannot make decisions on their own. Registered Nurse #12 also stated the risks for Resident #642 is that if they are not able to use the side rails on their own, they can hit their head, and the side rails can be considered a restraint because this resident moves on their own, they could get stuck in it and injured. Registered Nurse #12 further stated they completed a side rail assessment on 01/27/2026 and determined Resident #642 was an appropriate candidate for side rail use as they were able to hold on to the side rails when instructed and their family wanted to have the side rails in place. Registered Nurse #12 further stated that it was an oversight when they left the assessment form blank on areas where it asks if the family/resident are aware of the risks of side rails use and gives consent to the side rails. On 04/06/2026 at 1:05 PM, an interview was conducted with Assistant Director of Nursing #2 who stated Resident #642 had unwitnessed falls from the bed before side rails use and after side rails use because Resident #642 moves in the bed. The Assistant Director of Nursing #2 also stated side rails are an enabler and help Resident #642 to hold their position in place when they are asked to turn from side to side. The Assistant Director of Nursing #2 further stated staff reported that Resident #642 can move in the bed independently and that is why they fall, but they cannot put the side rails down by themself. The Assistant Director of Nursing #2 there is a risk if a resident is not able to use the side rail, as they can hit their head, so side rails could be viewed as a restraint and there could be an entrapment risk because Resident #642 can they move on their own and could get caught in the rails and be injured. The Assistant Director of Nursing #2 also stated the nurse should have ensured that the physician order was correct.On 04/06/2026 at 1:22 PM, an interview was conducted with the Director of Nursing who stated the nurse completes the side rail assessment and residents should be assessed quarterly for appropriateness of the side rail. The Director of Nursing also stated if a resident can follow the directions for use, they do receive enablers even if they have impaired cognition as an enabler can assist with the resident's bed mobility if the resident can hold on to the enabler while receiving care and side rails are not used for fall prevention. The Director of Nursing further stated that some possible risk for residents with enabler use is entrapment. The Director of Nursing stated the documentation in the side rails assessment should have been complete and the physician's order should have been correct. 10 New York Codes, Rules, and Regulation 415.4(a)(2-7)

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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** Number of residents sampled: 3Number of residents cited: 1Based on record review and interviews conducted during the survey the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are 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, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to the state agency. This was evident for one (1) of three (3) residents (Resident #273) reviewed for Accidents out of total 39 sampled residents. Specifically, the facility did not report Resident #273's incident of unknown origin, resulting in a nasal fracture, to the New York State Department of Health. The findings include: The facility's policy and procedure titled Abuse Reporting reviewed 05/2025 documented incidents suspected of abuse, neglect and exploration or misappropriation and serious injury of unknown origin that is suspicious in nature must be reported within two (2) hours after forming the suspicion to the New York State Department of Health. All other incidents must be reported within 24 hours. Resident #273 was admitted to the facility with diagnoses that included Cerebrovascular Accident, Seizure Disorder, and Parkinson's Disease.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #273 had severely impaired cognition and was dependent for toileting, roll left and right. The Nursing Note initiated 01/07/2026 and completed on 01/24/2026 documented on 01/07/2026 at approximately 05:30 PM, Licensed Practical Nurse #6 was conducting rounds and observed Resident #273 lying on the bedroom floor. Registered Nurse Supervisor #7 was notified. Resident #273 was noted with uncontrolled tremors and a small laceration on the bridge of their nose with active bleeding, and a small laceration to their mid forehead. The area was cleaned, pressure and ice pack applied. Resident #273 was unable to give details of the event. Medical Doctor and family were notified. Resident #273 was transferred to hospital for further evaluation. The Hospital Discharge summary dated [DATE] documented Resident #273 was admitted after fall incident in the nursing home facility. X ray was done and result showed fractures of the bilateral nasal bones and nasal septum. Resident #273 was also noted to have resting tremors during the hospitalization.The Nursing Note dated 01/08/2026 documented Resident #273 returned to facility around 12:44 AM, following hospital evaluation. The Fall/Occurrence Report documented on 01/07/2026 at 05:30 PM, Resident #273 was observed lying on the bedroom floor between bed A and B. Resident #273 has severely impaired cognition and was unable to give details of the event. The occurrence was a fall incident (not witnessed). Pain and skin assessments were done. Neuro check and treatment was given. Resident #273 was transferred to hospital on [DATE] and readmitted with nasal fracture and contusion to the forehead following the hospital evaluation.The facility's Summary of Investigation initiated 01/07/2026 documented that at 05:30 PM, Licensed Practical Nurse #6 was conducting rounds and observed Resident #273 lying on bedroom floor between bed A and bed B. Resident's head was towards the head of the bed; their legs extended towards the foot of their bed. Resident #273 was observed with uncontrollable tremors, and a pillow was under their head. Resident #273 was unable to state what happened. Resident #273 was assessed while on the floor and observed with a small superficial laceration on the bridge of their nose and mid forehead measuring 0.5 centimeter each with active bleeding. Doctor and family were notified, and resident was transferred to hospital for evaluation. Resident #273 returned to the unit on 01/08/2026 with hospital diagnosis of a nasal fracture. The facility concluded that Resident #273 was having tremors due to Parkinson's disease and may have rolled out of bed onto the floor. The investigation has revealed that there is no evidence to support that any alleged resident abuse, neglect, or mistreatment may have occurred. The incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not reportable to Department of Health. There was no documented evidence that Resident #273's incident resulting in nasal fracture and lacerations to forehead and bridge of the nose was reported to the New York State Department of Health. On 04/02/2026 at 10:57 AM, the Assistant Director of Nursing was interviewed and stated Resident #273 was assessed immediately by Registered Nurse Supervisor and was observed having uncontrollable tremors. The Assistant Director of Nursing also stated Resident #273 may have rolled out of bed due to their unpredictable movement, or possibly seizure episode due to their diagnoses. The Assistant Director of Nursing further stated they were notified on 01/07/2026 when Resident #273 was being sent out to the hospital, and they found out about Resident #273's nasal fracture on the following morning on 01/08/2026. The Assistant Director of Nursing #2 stated that they did not suspect abuse or neglect occurred for Resident #273, so the fall was not considered reportable. On 04/03/2026 at 2:12 PM, the Director of Nursing was interviewed and stated investigation of all incidents is conducted by a Registered Nurse Supervisor, and the Assistant Director of Nursing is responsible for reviewing and reporting the incident to Director of Nursing and Risk Manager. The Director of Nursing also stated that they and the Administrator will decide if this is reportable to the state agency. The Director of Nursing further stated this incident was not reported to the New York State Department of Health because the facility did not suspect any abuse or neglect occurred for Resident #273. On 04/06/2026 at 12:24 PM, the Administrator was interviewed and stated they did not report this incident to the New York State Department of Health because it was determined not reportable. The Administrator also stated Resident #273 was found on the floor and was having an epileptic seizure which is likely to cause an injury, so they concluded very quickly that it was not an abuse incident. 10 New York Codes, Rules and Regulations 415.4(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1Based on record review and interviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice. This was evident for one (1) of three (3) residents (Resident #696) reviewed for Hospitalization out of 39 sampled residents. Specifically, Resident #696 had a change of condition and Urinalysis/Polymerase Chain Reaction testing (method to detect and identify pathogens (things that cause disease) was ordered on 02/09/2026 and results were not received until 02/19/2026 which confirmed that Resident #696 had a urinary tract infection. In addition, there was no documented evidence that the Medical Doctor and Resident #696's representative were notified when Resident #696 refused to provide a urine sample.The findings include:The facility's policy and procedure titled Resident Change in Condition effective date 03/2026 documented that it is facility's policy to establish a standardized process for early recognition, timely notification and appropriate intervention. The goal is to prevent decline, ensure timely medical treatment and maintain the highest practicable level of resident well-being. The facility's policy and procedure titled Diagnostic Service Laboratory Services reviewed 01/2024 documented laboratory services are performed to ensure that residents receive appropriate clinical laboratory services. That the values are communicated for follow up in an efficient manner. Resident #696 was admitted to the facility with diagnoses that included Hypertension, Diabetes Mellitus, and Chronic Kidney Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #696 had moderately impaired cognition, required dependent assistance for toileting, and was always incontinent of urine. The Care Plan for Alteration in Bowel and Bladder Elimination initiated 06/12/2025 documented interventions which included provide brief change/check every two (2) to four (4) hours and as needed, monitor labs as scheduled, and encourage proper hand washing. The Care Plan for Fever/Hyperthermia initiated 02/12/2026 documented interventions which included assess/identify source of increased body temperature, lab tests as per physician order, monitor temperature/vital signs, offer ample fluids and monitor intake. The Physician Order entered 02/09/2026 at 01:03 PM and discontinued on 02/09/2026 at 03:03 PM documented Urine Sample for Urinalysis/Urine Polymerase Chain Reaction one time for fever. The Nursing Note dated 02/09/2026 at 02:36 PM documented Resident #696 was observed with increased temperature of 101.9-degree Fahrenheit during wound rounds. Vitals signs were checked. Medical Doctor was notified and ordered tests to rule out respiratory viruses and urinary tract infection. Tylenol Extra Strength 500 milligrams two (2) tablets every eight (8) hours as needed for fever. Resident #696's family was notified and updated on their status. Staff will continue to monitor and report changes accordingly. The Physician Orders entered 02/09/2026 at 03:03 PM for Urine Sample for Urinalysis/Urine Polymerase Chain Reaction one time for fever was documented as discontinued on 02/13/2026 at 03:16 PM after completion.The Diagnostic Result for Complete Blood Count dated 02/10/2026 documented [NAME] Blood Count level of 12.56 milligrams per deciliter (Reference Range 4.23-9.07), Blood Urea Nitrogen level of 42 milligrams per deciliter (Reference Range 9-23) and Creatinine level of 2.62 milligrams per deciliter (Reference Range 0.70-1.30) were abnormal.The Nursing Note dated 02/10/2026 at 04:22 PM written by Licensed Practical Nurse #11 documented no urine obtained on tour.The Nursing Note dated 02/10/2026 at 10:30 PM documented Resident #696 is alert and responsive, was to have urine collected but was uncooperative. Nursing Supervisor was informed and directed to collect another sample. The Nursing Note dated 02/11/2026 at 06:51 AM documented unable to obtain urine sample. The Nursing Note dated 02/12/2026 at 03:55 PM written by Licensed Practical Nurse #11 documented no urine obtained on tour.There was no documented evidence that the Medical Doctor was notified when the specimen for urinalysis was not collected. In addition, there was no documented evidence that staff attempted to obtain urine specimen on the following shifts: 02/09/2026 from 7:00 AM to 3:00 PM, 02/09/2026 from 3:00 PM to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:00 PM shift, 02/10/2026 from 11:00 PM to 7:00 AM, 02/11/2026 from 7:00 AM to 3:00 PM, 02/11/2026 from 3:00 PM to 11:00 PM, and on 02/12/2026 from 11:00 PM to 7:00 AM.The Nursing Note dated 02/12/2026 at 10:16 PM documented urine sample collected and placed in refrigerator.The Nursing Notes dated 02/13/2026 at 11:45 AM, documented Resident #696's family was called and informed of the negative results for COVID-19/Respiratory Influenza and urine result is pending. The Nursing Progress Notes dated from 02/14/2026 to 02/17/2026 did not contain any ongoing monitoring and assessment of resident's condition.The Nursing Note dated 02/17/2026 at 10:35 PM, documented received call from lab to send another urine sample. Lab was unable to perform test. Urine collected and placed in refrigerator. There was no documented evidence that the Medical Doctor was informed of the delayed Urinalysis/Polymerase Chain Reaction test result. The Nursing Note dated 02/18/2026 at 07:37 AM documented urine was collected by the laboratory staff.The Nursing Note dated 02/18/2026 at 02:43 PM documented Resident #696 was observed with poor appetite, breakfast and lunch input was observed less than 25%; offered alternative and refused. Upon responding to the room, the resident noted to be alert and verbally responding, in no noted distress, denies any pain and no clinical signs observed. Vital signs, temperature were taken. Medical Doctor notified and gave no new orders. Resident #696's family was updated on the status. Staff will continue to monitor and report changes accordingly.The Nursing Note dated 02/18/2026 at 03:50PM documented staff reported that resident refused to eat his breakfast and lunch intake very poorly. Vital signs taken. Medical Doctor was made aware.The Nursing Note dated 02/19/2026 at 06:59 AM documented Resident #696 noted with elevated temperature during shift 101.3 degrees Fahrenheit and Tylenol 325 milligrams two(2) tablets administered as prescribed. Subsequent reassessment revealed temperature returned to within normal limits with no signs of acute distress. Will continue to monitor and follow plan of care. Vitals within residents' trend. The Medical Note dated 02/19/2026 at 09:24 AM documented Resident #696 with altered mental status and fever. Spoke to Resident #696's family that given decreased mentation, low blood pressure, fever and hypoxemia, family understands Resident #696 could be septic. Resident #696's family requested transfer to the hospital. The Transfer to Acute Hospital Form completed on 02/19/2026 documented Resident #696 was transferred to the hospital due to low blood pressure, hypoxemia, fever, to rule (low levels of oxygen in the blood) out sepsis (a life-threatening illness that develops when an existing infection causes an extreme immune response in the body). The Urine Polymerase Chain Reaction Test ordered 02/09/2026 documented it was collected on 02/17/2026 at 3:00 PM and results received on 02/19/2026 at 8:12 AM which documented that the test was positive for Streptococcus group B and Candida. Licensed Practical Nurse #11 was unavailable for interview as they were on leave. On 04/06/2026 at 11:18 AM, Registered Nurse #6 was interviewed and stated on 02/09/2026 they received a report that Resident #696 was having a fever, so they checked vital signs and notified the Medical Doctor immediately who ordered urinalysis, blood tests, chest x ray, COVID 19, Influenza, Respiratory Syncytial Virus testing and that Tylenol was to be given for fever. Registered Nurse #6 also stated rapid testing was conducted which was negative for COVID-19 and Influenza and swab was also collected/placed in the refrigerator for PCR test on 02/09/2026. The urine sample collection was also attempted by them but could not be collected because Resident #696 could void at that time. Chest x ray showed no irregularities. Registered Nurse #6 further that on 02/10/2026 they attempted to collect urine using a condom catheter, but urine could not be collected. Registered Nurse #6 stated that after three refusals and after three days of failed collection they will notify the Medical Doctor, and nurses were also checking vital signs including temperature every shift until Resident #696 to rule out any suspected infection. Registered Nurse #6 stated they expect nurses to communicate with the nurse on the incoming shift and to document if urine collection could not be done until it was completed.On 04/01/2026 at 02:45 PM, Centers Laboratory Staff were interviewed over the phone and stated a lab technician visits the facility daily at 4:00 AM to draw blood for tests that were ordered. The lab technicians will also review the urine test order form in the binder indicating that urine was collected (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and placed in the refrigerator for the technician to pick up, and they will initial when it is picked up. The Centers Laboratory Staff also stated that the urine test results take two (2) days to become available, and the lab technician picked up the urine on 02/13/2026 so they would have known by 02/15/2026 if there was any issue. The Centers Laboratory Staff further stated they will reach out to the facility's supervisor immediately if there was any issue with the sample and if another urine sample needed to be collected. The Centers Laboratory Staff stated an attempt was probably made to inform the facility that the test needed to be repeated on 02/15/2026, but they could not explain why facility staff could not be reached on 02/15/2026 and 02/16/2026 and were not contacted until 02/17/2026. The Centers Laboratory Staff stated a technician picked up another urine sample on 02/18/2026 and the result was sent to the facility electronically on 02/19/2026.On 04/06/2026 at 11:59 AM, Licensed Practical Nurse #4 who worked on 02/09/2026 during the 7:00 AM to 3:00 PM shift, was interviewed and stated the wound nurse made the team aware of Resident #696's change in condition. Licensed Practical Nurse #4 also stated that after the tests were ordered, they tried collecting urine, but Resident #696 could not void urine. Licensed Practical Nurse #4 further stated they and Licensed Practical Nurse #11 tried the condom catheter method on 02/09/2026 but urine could not be collected. Licensed Practical Nurse #4 stated they did not know why there was no documentation in the medical record regarding the urine not being obtained due to Resident #696's refusal or not being able to void urine, however, the urine was sent out to the laboratory a few days later. Licensed Practical Nurse #4 also stated they did not notify the nursing supervisor and Medical Doctor until Resident #696 had refused to cooperate with the urine collection for three (3) days. On 04/01/2026 at 03:15 PM, Licensed Practical Nurse #7 was interviewed over the phone and stated they can only recall that they collected the urine sample on 02/12/2026 during the 3:00 PM to 11:00 PM shift and placed it in the refrigerator. Licensed Practical Nurse #7 stated they found out that the urine sample was picked up for processing when they came back to work, and they do not recall what occurred after that.On 04/04/2026 at 01:55 PM, Licensed Practical Nurse #5 was interviewed and stated that they were a floating nurse when they were told to collect urine specimen and swab for COVID 19 for Resident #696 during on 02/10/2026 during the 3:00 PM to 11:00 PM shift. Licensed Practical Nurse #5 also stated Resident #696 was incontinent and was receiving care and they explained the urine collection process, but Resident #696 refused to give urine. Licensed Practical Nurse #5 further stated they informed Registered Nurse Supervisor #5 of Resident #696's refusal on 02/10/2026 during the 3:00 PM to 11:00 PM shift.On 04/02/2026 at 11:15 AM, Registered Nurse Supervisor #5 stated they are often the covering Supervisor during the 3:00 PM to 11:00 PM shift, and Licensed Practical Nurse #5 called them and reported that urine could not be collected for Resident #696 because of their refusal on 02/10/2026 during the 3:00 PM to 11:00 PM shift. Registered Nurse Supervisor #5 also stated they attempted to collect urine twice during the 3:00 PM to 11:00 PM shift on 02/10/2026, but Resident #696 refused. Registered Nurse Supervisor #5 further stated they are aware that the Medical Doctor should be notified of a residents' refusal of urine collection, and it should be documented in the progress notes, so the Medical Doctor can address the concerns and consider an alternative method like using straight catheterization. Registered Nurse Supervisor #5 stated the family is notified of refusal as well because they can assist with the process, however they did not notify the family of Resident #696's refusal on 02/10/2026. On 04/06/2026 at 10:52 AM, the Assistant Director of Nursing was interviewed and stated if the resident refused or staff is not able to collect urine for three (3) days then the doctor and family should be notified.On 04/03/2026 at 2:34 PM, the Director of Nursing was interviewed and stated the urinalysis order was a one-time order, not an immediate order, so the night shift nurse should have collected the urine during their shift and placed it in the refrigerator for pick up the next morning. The Director of Nursing also stated the nurses should have documentation about the progress of the collection and any concerns in the progress notes. The Director of Nursing further stated that the Medical Doctor and family are notified after three days of attempting urine collection. 10 New York Codes, Rules, and Regulations 415.12