| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 335649 | A. Building<br>B. Wing | 05/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| North Gate Health Care Facility | 7264 Nash Road<br>North Tonawanda, NY 14120 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews conducted during a survey, the facility failed to ensure that a resident with pressure ulcers (ulcers on the skin due to prolong pressure) received necessary treatment and services, consistent with professional standards of practice, to promote healing, and prevent infection for three (3) (Residents #14, #57, and #207) of eight (8) residents reviewed for pressure ulcers. Specifically, there was lack of initial staging, description and measurements of pressure ulcers upon admission (Resident #57), there was a delay in initiating treatment and lack of an assessment to determine the type of wound present upon admission (Resident #207), and lack of weekly monitoring, including a description and measurements of pressure ulcers (Resident #14). Additionally, treatments were not documented as completed (Residents #57 and #14) and there was a delay in initiating a wound consultant recommendation (Resident #14). The findings include:The facility policy and procedure titled Documentation of Pressure Ulcer and Chronic Wounds dated 6/23 documented risk factors will be identified, monitored and documented on the Skin Risk Data Collection Tool; upon admission, then quarterly or whenever there is a change in condition. An ongoing inspection and assessment of all pressure sores and chronic wounds will be conducted weekly and as needed. All pressure ulcers wound dressing will be inspected daily. The Assistant Director of Nursing (or skin nurse as designated by the Director of Nursing) will be the official baseline and subsequent reference point for all skin/wound assessments. The policy documented the Assistant Director of Nursing or designee was responsible for initiating the weekly skin status evaluation when a pressure ulcer is identified. The template contains the following: type of area, site, stage, description characteristics, treatment, debridement, exudate (drainage), pain management, teaching and additional comments. The facility policy and procedure titled Physician Orders dated 7/2025 documented the policy was to assure that medication/treatment orders are implemented accurately, timely and in accordance with the Health Code of the State of New York and Federal Government regulations. 1. Resident #57 had diagnoses including kidney transplant failure, dependence on renal dialysis and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated 05/02/2026 documented Resident #57 had moderate cognitive impairment, was understood, and understands. The assessment tool documented the resident had three (3) stage II (partial-thickness skin loss into but not deeper than the dermis) pressure ulcers that were present upon admission. The Comprehensive Care Plan revised on 05/11/2026, documented Resident #57 was at risk for impaired skin integrity related to stage II ulcers to their right and left buttock. Interventions included administering preventative treatment per medical doctor order, monitoring skin for changes daily during care; apply moisture barrier following incontinence care, turn and reposition every two (2)- (4) four hours, pressure reduction mattress and skin risk tool per policy. The care plan documented Resident #57 had impaired skin integrity related to pressure area to their buttocks. Interventions included to administer treatment per medical doctor's order, evaluate and measure skin/wound sites at least weekly and document outcome and treatment progress/changes, monitor for infection; and medical provider evaluation as needed. Review of the Nursing admission Evaluation dated 04/28/2026 at 9:32 PM, Licensed Practical Nurse #4 Unit Coordinator documented Resident #57 had open areas to<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the right and left buttocks- three (3) areas total. The evaluation did not include the type, the stage, measurements or descriptions of the areas. This was cosigned by Registered Nurse #2 Director of Rehab on 05/08/2026. Review of the Nursing Skin Risk Data Collection Tool dated 04/28/2026 at 9:52 PM, Licensed Practical Nurse #4 Unit Coordinator documented Resident #57 was at risk for pressure ulcers. Review of the interdisciplinary Progress Notes from 04/28/2026-05/07/2026 revealed no documented evidence of an evaluation of the type, the stage, measurement or description of Resident #57's open areas they had upon admission. Review of the Medical Visits Notes from 04/29/2026-05/07/2026 revealed no documented evidence of an evaluation of the type, the stage, measurement or description of Resident #57's open areas they had upon admission. Review of the Nursing Weekly Skin Status Documentation dated 05/08/2026 at 1:21 PM, Registered Nurse #2 Director of Subacute documented Resident #57 had a stage II pressure ulcer measuring 3 centimeters (length) x (by) 2.5 centimeters (width) x 0.1 centimeters (depth) to their sacrum (area above the tailbone on the right and left buttocks); a pressure ulcer measuring 1.5 centimeters (length) x 1.5 centimeters (width) x 0.1 centimeters (depth) to their right buttock (no stage was indicated); and a stage II pressure ulcer measuring 2.5 centimeters (length) x 2 centimeters (width) to their left buttock. Treatments included Alginate (highly absorbent dressing made of calcium and sodium) with dry clean dressing with calmoseptine (skin protectant) to surrounding intact tissue. It was documented as an addendum note for 05/04/2026. Review of the Order Summary Report dated 05/11/2026 documented Resident #57 had an order with start date of 04/28/2026 to apply calcium alginate every day shift to the three (3) open areas to their right and left buttocks after cleaning with normal saline then cover with a dry clean dressing. Resident #57 had an order to apply calmoseptine ointment to the affected area every day and evening shift. The Calmoseptine order was discontinued on 05/09/2026. Review of the Treatment Administration Record from 05/01/2026-05/10/2026 documented Resident #57's was to have:-calcium alginate every day shift to three (3) open areas to their right and left buttocks after cleaning with normal saline to then cover with a dry clean dressing. There were no initials that documented the treatment was completed from 05/01/2026 through 05/05/2026 and on 05/08/2026.-calmoseptine ointment applied to the affected area every day and evening shift started on 04/28/2026. There were no initials that documented the treatment was completed on the day shift from 05/01/2026 through 05/05/2026 and on 05/08/2026. There were no initials that documented the treatment was completed on the evening shift for 05/02/2026 and 05/04/2026. This order was discontinued on 05/09/2026. During an interview on 05/08/2026 at 1:00 PM, Resident #57 stated they had two open areas on their buttocks, and those areas were washed daily. They stated the certified nurse aides would put the cream in an orange tube on their buttocks daily, not the nurses, when the aides got them washed for the day. During a wound care observation and interview on 05/08/2026 at 3:49 PM, Licensed Practical Nurse #9, in the presence of the Director of Education, performed wound care on Resident #57 per the medical provider orders. The Director of Education stated they would describe Resident #57's sacrum/buttocks open areas as the upper area being a stage II pressure ulcer and the bottom area was closed (healed). During an interview on 05/12/2026 at 3:48 PM, Licensed Practical Nurse #4 Unit Coordinator stated they were responsible for doing an initial skin assessment on new admissions but as a licensed practical nurse they were unable to stage or measure any pressure ulcers. They stated the process for a new skin issue was they would take a picture of the wound and send it to Registered Nurse #2 Director of Subacute who then would instruct what treatments to put into place. After reviewing the electronic medical record, Licensed Practical Nurse #4 Unit Coordinator stated Resident #57's first staging and measurements of their pressure ulcers were completed on 05/08/2026 in the weekly skin notes documented by Registered Nurse #2 Director of Subacute. 2. Resident #14 had diagnoses including hypertension, heart failure and chronic kidney disease. The Minimum Data Set, dated [DATE] documented Resident #14 was cognitively intact, was understood, and understands. The assessment tool documented that the resident had two (2) deep tissue injuries (pressure-induced damage that begins in the underlying<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | muscle, fat, or subcutaneous tissue, often near bone, while the skin may remain intact or appear discolored) that were not present upon admission. The Comprehensive Care Plan revised on 02/16/2026 documented Resident #14 was at risk for impaired skin integrity related to limited mobility. Interventions included administering preventative treatment per medical doctor order, monitoring skin for changes daily during care, updating the medical provider with skin changes, turn and reposition every two (2)- (4) four hours, use a pressure reduction mattress, skin and feet check daily, and skin risk tool per policy. The care plan documented Resident #14 had impaired skin integrity related to a right heel pressure area. Interventions included administering treatment per medical doctor's order, evaluating and measuring skin/wound sites at least weekly and documenting the outcome and treatment progress/changes, and a medical provider evaluation as needed. Review of the Nursing Weekly Skin Status Documentation form dated 02/20/2026 at 1:33 PM documented Resident #14 had a suspected deep tissue injury on the right heel measuring 3.5 centimeters (length) x 5 centimeters (width) and a suspected deep tissue injury on the left heel measuring 1 centimeter (length) x 1 centimeter (width). Treatments included applying tincture (skin protectant, adhesive enhancer, and mild antiseptic), pad and wrap daily. This note was not signed by any staff including the date the note was completed. The next Nursing Weekly Skin Status Documentation form with an effective date of 03/10/2026 at 4:38 PM was signed as completed by Registered Nurse #2 Director of Subacute on 03/15/2026 and documented Resident #14 had a suspected deep tissue injury on the right heel measuring 3.5 centimeters (length) x 3.5 centimeters (width), and a suspected deep tissue injury on the left heel measuring 0.5 centimeters (length) x 0.5 centimeters (width). Treatments included applying tincture, pad and wrap daily. There was no weekly monitoring/assessment of the suspected deep tissue injury on the heels. Review of the interdisciplinary Progress Notes from 02/20/2026-03/15/2026 revealed no documented evidence of an evaluation of the type, the stage, measurement or description of Resident #14's pressure areas on their heels. Review of the Medical Visits notes from 02/20/2026-03/15/2026 revealed no documented evidence of an evaluation of the type, the stage, measurement or description of Resident #14's pressure areas on their heels. Review of the Wound Care Assessment/Consultation note dated 04/28/2026, Nurse Practitioner #2 documented Resident #14 had a stage III (skin injury characterized by full-thickness skin loss, exposing the fatty tissue beneath) pressure ulcer measuring 2.3 centimeters (length) x 2.0 centimeters (width) x 0.1 centimeters (depth) to their right heel that they debrided (removal of dead, damage or infected tissue) the area. Nurse Practitioner #2 documented they recommended the treatment of Santyl (an ointment used to remove dead or damaged tissue) with a dry clean dressing daily to Resident #14's right heel. Review of the Order Summary Report dated 05/11/2026 documented Resident #14 had an order to apply benzoin tincture to both heels, pad and wrap with start date of 02/20/2026 that was discontinued. There was an active order dated 05/06/2026 for Santyl to the right heel, pad and wrap daily. Review of the Treatment Administration Record from 05/01/2026-05/11/2026 documented Resident #14 was to have benzoin tincture to the right heel, pad and wrap daily that was discontinued 05/06/2026 and then start Santyl to right heel, pad and wrap daily starting on 05/07/2026. The benzoin tincture treatment was documented on 05/01/2026 as 9 (other) by Licensed Practical Nurse #8 and on 05/06/2026 the treatment was blank (not signed as completed). Review of the Medication Admin Audit Report dated 05/12/2026 documented Resident #14's benzoin tincture treatment for 05/02/2026-05/05/2026 was completed by the Director of Nursing. The report documented that the Director of Nursing did not sign for those treatments as completed until 05/11/2026. During a wound care observation and interview on 05/11/2026 at 1:04 PM, Licensed Practical Nurse #5 performed wound care on Resident #14 per the medical provider orders. While the treatment was being completed, Resident #14 stated the nurse yesterday told them they needed to have their treatments to the heels completed every day because there was no dressing on their foot. During an interview on 05/12/2026 at 9:55 AM, Licensed Practical Nurse #7 stated on 05/04/2026 they believe they did not have time to complete their treatments on the E unit<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and if they did not sign them off in the electronic treatment administration record then they did not do them. They stated they reported to the next incoming shift they did not complete their treatments but did not recall who that staff member was. Licensed Practical Nurse #7 stated it was hard to complete treatments on the day shift on the E unit because there was a large volume of medications to be administered, then the residents were usually in dialysis, then to therapy and then visiting with their families. Licensed Practical Nurse #7 stated the importance of completing the residents' treatments was to get the residents better. During an interview on 05/12/2026 at 10:06 AM, Licensed Practical Nurse #11 stated they did not do their treatments on 05/05/2026 because they were told there was a treatment nurse that day. During a telephone interview on 05/12/2026 at 12:23 PM, Licensed Practical Nurse #8 stated that if on 05/01/2026 they did not sign off their treatments in the electronic treatment administration record then they did not do the treatment because they did not have time to do them. Licensed Practical Nurse #8 stated they were not familiar with Resident #57 but very familiar with Resident #14. They stated they have only ever completed a skin tear treatment to Resident #14's leg, not any treatments to their heels. They stated it was important to sign out treatments when completed because it documented the treatment was completed and doing treatments per medical provider's order helped the resident heal. During a telephone interview on 05/12/2026 at 12:40 PM, Registered Nurse #4 stated that if they did not sign off their treatments in the electronic treatment record then they did not do the treatment. They stated when they pick up time for the facility they only worked from 7:00 AM- 1:00 PM and usually do not have time to complete any treatments. Registered Nurse #4 stated they were not sure who replaced them on 05/03/2026 but when they leave their shift they would report to the other floor nurses what duties they could not complete. Registered Nurse #4 stated it was important to sign off treatments when completed because if you do not sign it, you did not do it, and it was important to complete treatments per medical providers order because the skin issue could get worse or lead to infection. During a telephone interview on 05/12/2026 at 11:59 AM, Nurse Practitioner #2 stated they were the wound consultant for the facility and would see residents by request of the facility. They stated they saw Resident #14 on 04/28/2026 for the first time and at the visit they performed debridement to their right heel to remove an unstable heel cap (area of hard necrotic (dead) tissue). Nurse Practitioner #2 stated they recommended changing Resident #14's treatment to Santyl and would imagine the facility would follow their recommendation at the time of the recommendation since they were asked to do a consultation. During an interview on 05/12/2026 at 3:53 PM, Registered Nurse #2 Director of Subacute stated they were responsible for measuring and staging pressure ulcers on their unit and the Assistant Director of Nursing would be their back up. They stated when there was a newly identified skin issue it should be measured and staged no later than the very next day/business day. After reviewing the admission note for Resident #57, Registered Nurse #2 Director of Subacute stated there were no measurements or staging for the pressure ulcers to their right and left buttocks until the weekly skin notes on 05/08/2026 and written on the note was an addendum that the measurements were completed on 05/04/2026. Registered Nurse #2 Director of Subacute stated the pressure ulcers should had been staged and measured by 05/01/2026 and that they missed it. After review of Resident #57's electronic treatment administration record, Registered Nurse #2 Director of Subacute stated that not all the resident's treatments were signed as completed, they did not know if Resident #57's treatments were completed daily because they were not signed off and they would expect treatments to be signed off at completion time. Registered Nurse #2 Director of Subacute stated that on 05/05/2026 they completed Resident #57's treatment themselves and did not sign them off. After review of electronic medical record for Resident #14, Registered Nurse #2 Director of Subacute stated that a weekly skin assessment was started on 02/20/2026 by Registered Nurse #3 and there was no documented evidence that the areas were being measured, staged and described weekly until 03/10/2026. They stated the importance of documenting measurements, staging and describing a wound on a weekly basis was to ensure the treatments were appropriate along with the<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staging. Registered Nurse #2 Director of Subacute stated that Resident #14 was seen by Nurse Practitioner #2 on 04/28/2026 and they had recommended changing the treatment to Santyl after the wound was debrided. They stated they missed changing Resident #14's order until 05/06/2026 but should have changed the treatment at the time of the recommendation. During an interview on 05/12/2026 at 4:30 PM, the Director of Nursing stated the process for when there was a new skin issue on the E unit was the Licensed Practical Nurse Unit Coordinators were to notify a Registered Nurse to determine the skin treatment. They stated that the Licensed Practical Nurses could not stage or measure any pressure ulcers and they would expect Registered Nurse #2 Director of Subacute or Registered Nurse #1 Unit Coordinator to do so within the first 48 hours of discovery of the wound. The Director of Nursing stated all skin issues were documented in the electronic medical record on the Nursing Weekly Skin Status Documentation form. The Director of Nursing stated the pressure ulcer treatments were not signed as completed every day, but they completed Resident #57's treatments on those days and failed to document them as completed. They stated they expected that there was documented staging and measurement within 48 hours of the wound being identified and then weekly after. The Director of Nursing stated they also did Resident #14's treatment on 05/02/2026-05/05/2026 but did not document them as completed until 05/11/2026 because they did not have computer access on the unit and then they got distracted. They stated they should have signed off at the time of completion, so they did not forget to sign them off, to monitor if there was any improvement, and it was a professional standard to sign off the treatments at the time they were completed. The Director of Nursing stated it was important to document skin staging, measurements and description of the pressure wounds to know if the resident came in with a wound or if it developed in the facility. They stated they expected pressure ulcer treatments that were recommended by the wound specialist to be implemented within five (5) days of the recommendation. During a telephone interview on 05/13/2026 at 11:17 AM, the Medical Director stated they expected pressure ulcers would be managed through the wound management team. They would expect the pressure ulcers documentation to include an assessment, plan and follow-up in the electronic medical record. They stated they would defer to facility protocol for documentation but the more the better and it should be completed at least weekly. The Medical Director stated they would expect all wound specialist recommendation to be followed. They stated that there should be ongoing documentation about a resident's medical status and all medications and treatments to be documented as completed when administered for continuum of care and for all to be aware of any changes with the residents.<br>3.Resident #207 had diagnoses including fracture of the left pubis (break of the pelvic ring on the left side), facture of right humerus (break in the upper arm bone on the right side), fracture of olecranon process (break in the bony tip of the elbow) and need for assistance with personal care. The Minimum Data Set, dated [DATE] documented Resident #207 was understood, understands others and was cognitively intact. Resident #207 was dependent on staff for bed mobility, transfers and was at risk of developing pressure ulcers/injuries. Resident #207 did not present with any skin conditions. The Kardex (a guide used by staff to direct care) dated 01/28/2026 and 02/11/2026, documented for skin integrity the resident was to go back to bed after meals as tolerated and staff were to monitor skin for changes daily during care. There was no documented evidence regarding use of barrier cream. The Comprehensive Care Plan revised on 01/30/2026 documented that the resident had impaired skin integrity related to impaired mobility, moisture/incontinence, and several fractures. They were at risk for impaired skin integrity related to anticoagulation (blood thinner) therapy, frequent injury/falls, and moisture/incontinence. Interventions included monitoring the site for signs/symptoms of infection, administer preventative treatment per doctor's order, and monitor skin for changes daily during care. On 02/16/2026 the impaired skin integrity care plan was revised related to a wound on the right inner buttocks. The Nursing admission Evaluation dated 01/28/2026 at 6:39 PM completed by Licensed Practical Nurse #4 Unit Coordinator, documented the resident had skin conditions/abnormalities noted with redness to their right groin and bilateral buttocks. Registered Nurse #1, Unit Coordinator signed<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on 01/30/2026 that they reviewed/approved the nursing admission evaluation. The Nursing Weekly Skin Status Documentation dated 01/28/2026 at 6:34 PM completed by Licensed Practical Nurse #4 Unit Coordinator, documented the resident had redness to the right groin and bilateral buttocks with a treatment of house cream with zinc to be applied. Interventions for impaired skin integrity related to skin injury included the resident was to go back to bed after meals as tolerated. There were no additional Nursing Weekly Skin Status Documentation forms completed after 01/28/2026 that documented the type, a description of, or measurements of the redness and/or of wounds. The Order Summary Report dated 05/08/2026, documented an order started on 02/05/2026 for Clindamycin-Tretinoin External Gel (combination antibiotic and retinoid to treat inflammatory breakouts) 1.2-0.025 percent, apply to right buttock, right hip topically two times a day for HS (Hidradenitis Suppurativa-chronic inflammatory skin condition) and an order for skin prep (topical application that toughens skin and enhances adherence of dressing) to heels at bedtime as preventative treatment. There was no documented evidence of any treatments or preventative treatments ordered for Resident #207 redness on buttocks from 01/28/2026 until 02/05/2026. The Treatment Administration Record dated January 2026 did not have any treatments documented related to the resident's buttocks. The Treatment Administration Record dated February 2026 documented a treatment for Clindamycin-Tretinoin External Gel 1.2-0.025 percent, apply to right buttock, right hip topically two times a day was started on 02/05/2026. Review of Progress Notes and Medical Visit Notes dated 01/28/2026 through 02/26/2026 documented the following: -02/11/2026 at 3:54 PM, Licensed Practical Nurse #3 documented wound care to right buttocks, and a dry clean dressing was applied. -02/15/2026 at 4:45 PM, Licensed Practical Nurse #3 documented wound care to right inner buttocks and a dry clean dressing was applied. -02/18/2026 at 12:32 PM, Nurse Practitioner #1 documented the resident had complaints of pain and bleeding from their sacral wound. A full skin exam was not completed, please see nursing documentation. -02/18/2026 at 4:08 PM, Licensed Practical Nurse #3 documented wound care to buttocks continues, dry clean dressing applied. Complaints offered about buttock discomfort. -02/19/2026 at 4:02 PM, Licensed Practical Nurse #3 documented wound care to buttocks, and a dry clean dressing was applied. -02/20/2026 at 11:00 AM, Nurse Practitioner #1 documented Resident #207 was in a chair upon examination and reported pain from their sacral wound. A full skin exam was not completed, please see nursing documentation. -02/20/2026 at 4:06 PM, Licensed Practical Nurse #3 documented wound care to sacrum. -02/23/2026 at 4:42 PM, Licensed Practical Nurse #3 documented wound care to buttocks continued. There was no documentation of weekly monitoring to include the type of wound, a description or measurements of the area on the resident's sacrum/buttocks. During a telephone interview on 05/08/2026 at 3:23 PM, Resident #207's family member stated the resident had a pressure ulcer to the middle of their butt that developed while at the facility that was red and very painful. They stated they observed this area while unknown staff were providing care to Resident #207. They stated the staff were aware of the area and they put a dressing on it. During a telephone interview on 05/08/2026 at 12:17 PM, Licensed Practical Nurse #3 stated Resident #207 had two (2) open areas, one on their sacrum and one to their right inner buttocks. They stated the areas were quite painful to Resident #207 and they medicated them for pain. They stated the right inner buttock wound was difficult to get to due to the resident's mobility. Licensed Practical Nurse #3 stated they did not recall the specific treatment but that they would have completed treatments per the treatment administration record and apply a dressing after applying the treatment to the wounds. They stated the wound assessments are completed by the unit coordinators when residents are admitted and treatments are implemented. During an interview on 05/08/2026 at 10:06 AM, Registered Nurse #1 Unit Coordinator stated any new skin breakdown, redness, or open areas are reported to Registered Nurse #2 Director of Subacute. They stated it was important to have treatments initiated for skin breakdown to prevent further breakdown and it should be documented to show awareness, acknowledgement of the skin breakdown. During an interview on 05/08/2026 at 10:11 AM, Registered<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Nurse #2 Director of Subacute stated if redness to buttocks is noted during an initial skin evaluation, it usually is not staged, Licensed Practical Nurses are just describing the skin and then there should be a Registered Nurse follow up on the admission skin assessment. They stated they did not follow Resident #207 but that any Registered Nurse could follow up on an admission skin assessment to determine if redness to buttocks is something or nothing. They stated it was important to determine if the area was blanchable versus non-blanchable (refers to whether skin redness temporarily turns white (blanches) when pressed), or pressure versus moisture associated skin damage. They stated they did not know if the redness to Resident #207's buttocks was blanchable or not, or if a treatment should have been initiated. They stated they did not know if the redness was pressure or moisture related. They stated they did not recall being made aware of the redness to Resident #207's buttocks and it was their responsibility to follow up on abnormal skin conditions and document it. They stated it would have been important to monitor the redness on Resident #207's buttocks to monitor for worsening, improvement, and need for further interventions. During an interview on 05/08/2026 at 11:26 AM, Registered Nurse #2 Director of Subacute stated Licensed Practical Nurse #4 Unit Coordinator can only describe wounds, they cannot assess them. They reviewed Resident #207's Nursing Weekly Skin Status Documentation dated upon their admission, 01/28/2026, in the electronic medical record and stated there should have been an order for house cream with zinc to be applied to Resident #207's bilateral buttocks as treatment of documented redness. During an interview on 05/08/2026 at 11:30 AM, Registered Nurse #1 Unit Coordinator stated they did not personally assess the redness to Resident #207 buttocks, but when redness is seen, a treatment order should be put into place to prevent further skin breakdown. They stated they are not trained in wounds and Registered Nurse #2 Director of Subacute would have determined if the redness to Resident #207 buttocks was pressure related. Registered Nurse #1 Unit Coordinator stated they could not recall if they brought Resident #207's skin condition to the attention of Registered Nurse #2 Director of Subacute. They stated Registered Nurse #2 Director of Subacute or themselves were responsible to ensure a treatment was followed through on and did not know why there was not a treatment ordered upon admission. During an interview on 05/08/2026 at 11:36 AM, Nurse Practitioner #1 stated the treatment order dated 02/05/2026 for Clindamycin-Tretinoin External Gel 1.2-0.025 percent had a typo, the treatment was for a rash, not Hidradenitis Suppurativa. They stated Resident #207 had a pimple like rash. They stated if they saw the rash they most likely only saw Resident #207's thigh area and not their buttocks. They stated if they had observed any bleeding they would have written that in their exam note for that day. Nurse Practitioner #1 stated it was important for abnormal skin findings to be brought to medical providers' attention for proper treatment to ensure there is no infection and proper treatment orders. They stated if Resident #207 had an open wound on their buttocks it should have been followed by the wound team, documented and followed up on. During a telephone interview on 05/08/2026 at 12:05 PM, Licensed Practical Nurse #4 Unit Coordinator stated upon admission residents' skin were checked and any skin concerns are documented. They stated open areas are communicated to Registered Nurse #2 Director of Subacute and they are given recommendations. They stated they are not allowed to stage pressure ulcers, that staging must be completed by a Registered Nurse. They stated if redness was observed, treatment should be implemented for protection or to prevent further progression. They stated they would not notify Registered Nurse #2 Director of Subacute of redness because they could address it themselves. During an interview on 05/13/2026 at 11:13 AM, the Director of Nursing stated they expected a complete skin assessment, full head to toe skin check, to be completed upon admission. They stated skin deterioration can happen very quickly and that areas of skin concern should be passed along to a Registered Nurse as soon as possible. They stated a house barrier cream treatment would be recommended to be applied to skin that was reddened and would be on the resident's treatment administration record. The Director of Nursing stated the treatment would be part of the residents' orders. They stated all Registered Nurses should be able to stage pressure ulcer/injury and<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | implement interventions to prevent, treat pressure ulcers. The Director of Nursing stated they expect all wounds to be assessed with a measurement, depth, description of wound bed, signs/symptoms of infection to be completed by a Registered Nurse and to ensure a treatment is present to prevent further deterioration. 10 New York Codes, Rules, and Regulations (NYCRR) 415.12(c)(2) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, interview, and record review conducted during the survey, the facility failed to ensure residents have the right to personal privacy including accommodations for one (1) (Resident #5) of one (1) resident reviewed. Specifically, a privacy curtain in the resident's room did not fully enclose Resident #5's bed. The findings include: The policy and procedure titled Dignity, Respect and Privacy in Treatment and Care dated 10/2023 documented the resident has a right to be treated with dignity, respect, privacy and security. Privacy is provided for Residents while being examined and treated. Curtains are drawn and people not involved in the care or treatment are not present while the Resident is being examined or treated without Resident's permission. Staff at all times provide privacy for the Resident when dressing, undressing, bathing and toileting.Resident #5 had diagnoses which included major depressive disorder, post-traumatic stress disorder and osteomyelitis (infection of the bone). The Minimum Data Set (a resident assessment tool) dated 04/26/2026 documented Resident #5 was usually understood, usually understands others and had moderate cognitive impairment.Review of the comprehensive care plan revised 06/08/2025 documented Resident #5 had an alteration in bladder function related to incontinence. Interventions included incontinent care as needed. Additionally, the comprehensive care plan documented Resident #5 was alert and oriented to their own identity, their current location, and the current time with mild cognitive impairment.On 05/08/2026 at 3:30 PM, maintenance request records were requested for Resident #5's room for the past 30 days. The facility was unable to provide any maintenance requests.During an observation and interview on 05/06/2026 at 9:44 AM, Resident #5 stated they did not feel like there was a lot of privacy in their room because their curtain needed another panel; it did not close all the way. Resident #5 stated that if their roommate were to leave their side of the room while Resident #5 was receiving care, their roommate would be able to see them. Resident #5 stated that knowing their roommate could see them receiving care at some point bothered them. When the curtain was pulled, it did not close all the way, leaving an open gap of approximately four (4) feet. Resident #5 stated they did not know when that curtain was hung or who had hung it up, but staff had commented to them that the curtain was not big enough.During an interview on 05/08/2026 at 1:21 PM Certified Nurse Aide #1 stated they noticed that Resident #5's privacy curtain did not go around their bed when they were doing care in the morning, but there was nothing they could do to fix that. They stated that if Resident #5's roommate on the window side of the room wanted to leave the room or come into the room during care, they would have to wait until Resident #5 was covered with a blanket. They stated that all the staff were aware that the curtain did not go around the bed, but everyone was too busy to fix it. Certified Nurse Aide #1 stated that the privacy curtain should have been closed completely because it was for Resident #5's privacy and dignity.During an observation and interview on 05/08/2026 at 1:27 PM, Licensed Practical Nurse #2 Unit Coordinator pulled Resident #5's privacy curtain closed and stated the curtain seemed short; it should have been longer because otherwise there was a very large gap at the end. They stated that the curtains should extend the full length of the curtain tracks on the ceiling to provide adequate privacy. They stated that Resident #5's roommate did usually leave the room around 7:00 AM and returned around 2:00 PM. They stated any staff who had noticed the curtain was not long enough for the area should have either notified them or put in a maintenance request.During an interview on 05/12/2026 at 8:34 AM, Certified Nurse Aide #2 stated they were aware of two privacy curtains on the unit that were too short and would not close all the way. They stated Resident #5's privacy curtain would not close all the way, and they were very lucky that Resident #5's roommate did not want to enter the room or leave the room when care was being done. They stated if it did happen, Resident #5's roommate would have to wait to leave or enter the room until Resident #5 was covered up. They should not have to wait to enter or leave their room. They stated maintenance was responsible for hanging up curtains and it was probably mentioned to them in the past that the curtain was too short.During an observation and interview on 05/12/2026 at 8:38<br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | AM, Maintenance #1 stated they were one of the maintenance floor workers and they were responsible for hanging up privacy curtains in the resident rooms. When Resident #5's privacy curtain was pulled, Maintenance #1 stated there was a big gap of at least three (3) or more feet. They stated the curtains should all be wide enough to enclose Resident #5 for privacy.During an interview on 05/12/2026 at 9:52 AM, the Director of Nursing stated their expectation that staff close the privacy curtain during any treatments that would expose a resident's private area. They stated that the privacy curtains should close all the way because it would provide privacy and dignity for the residents.During an interview on 05/12/2026 at 11:26 AM, the Administrator stated Resident #5 had never voiced concerns about their privacy curtain. They stated they did not know if it would register with their staff that a privacy curtain with a three (3) foot gap in coverage would be a privacy concern. They stated that perhaps the staff member who hung the curtain should have realized that the privacy curtain was not long enough. They stated they did not know if the staff on the unit would know that the privacy curtain should fully close. Maintenance was responsible for hanging privacy curtains in rooms. Every staff member was responsible for providing privacy to residents.10 New York Codes, Rules, and Regulations 415.3(e) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on interview and record review conducted during the survey, the facility failed to ensure that comprehensive care plans included to the extent practicable, the participation of the resident and the resident's representative(s); an explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan for one (1) (Resident #112) of one (1) reviewed for care plan participation. Specifically, Resident #112 was not invited to participate in their care plan meetings. The findings include: The facility policy and procedure titled Interdisciplinary Care Planning revised 9/2025, documented each resident and their family members and/or legal representative will be encouraged to participate in the development of the resident's comprehensive care plan. The Interdisciplinary Team will review the Care Plan as scheduled and the patient and/or family member(s) are invited to attend this review meeting. Revised May 2023 Job Title/Job Code titled Social Services Assistant, documented position assists in the planning, organizing and implementation of the Social Services Department; to assure that the medically related, emotional and social needs of the resident were met/maintained on an individual basis. Essential Duties and Responsibilities included to develop and maintain a good rapport with professional departments involved with the care plan to ensure that a team effort was achieved in the development of the comprehensive plan of care; types and mails all Team Care letters. Resident #112 had diagnoses including chronic obstructive pulmonary disease (lung disease), osteoarthritis (degenerative joint disease), and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 03/14/2026 documented Resident #112 was cognitively intact, understands and was understood by others. The Comprehensive Care Plan Report last reviewed 03/17/2026 documented Resident #112 had no alteration in psychosocial well-being and was independent with decision making skills. Interventions included: to remain involved in daily decisions/care; provide information to make safe/independent decisions, respect choices; invite to attend Comprehensive Care Plan Meetings; and invite responsible party to attend Comprehensive Care Plan Meetings. During an interview on 05/07/2026 at 9:03 AM, Resident #112 stated they have never been invited to attend a care plan meeting. They stated no one has ever asked them to attend, and they have never received an invitation/letter to attend their care plan meeting. During an interview on 05/12/2026 at 10:46 AM, Social Worker #2 stated the front desk receptionist sends letters to designated resident representatives and/or residents when their scheduled care review meetings were due. They stated if a family member wishes to attend, they contact the social worker to schedule a meeting. They stated they do not specifically invite residents to attend their care plan meeting. They stated if a resident was their own responsible party, then they should receive a letter regarding their care plan meeting. During an interview on 05/12/2026 at 3:01 PM, Receptionist #1stated they were emailed a list of care plan reviews due, by the Medical Records Manager. They utilize that list to send letters out to the responsible party notifying them of the care plan meeting date and name of social worker. They stated they go by the indicated responsible party in the resident electronic medical record to determine who the letter is sent to. They stated if a resident is their own responsible party, the letter is given to the activities department to deliver to the resident, otherwise the letter is mailed out to the responsible party. Receptionist #1 reviewed Resident #112's contact information in the electronic medical record and stated Resident #112's care plan meeting letters were mailed to their responsible party, indicating a family member, not Resident #112. They stated they did not know why Resident #112 was not their own responsible party. Review of Resident Contacts dated 05/12/2026 at 3:04 PM, revealed there was documented contact type assigned to Resident #112. During an interview on 05/12/2026 at 3:16 PM, the Quality Compliance Registered Nurse stated Resident #112 should have been informed and invited to their care plan meetings because they were an active part of their care<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and should be involved. During an interview on 05/12/2026 at 3:38 PM, Resident #112 stated it would be important to them to be invited to attend their care plan meetings, as it would enlighten them on what was going on with their care. During an interview on 05/13/2026 at 10:31 AM, Social Worker #2 stated they were not aware that Resident #112 was not being invited to attend their care planning meeting and that they specifically did not ask Resident #112 to attend. They stated they did not believe that Resident #112 had attended their care plan meeting in a while. They stated Resident #112 should have been invited to attend the meetings because they were their own decision maker. During an interview on 05/13/2026 at 11:23 AM, the Administrator stated the social workers were responsible for inviting residents to their care plan meeting. They stated it was important for residents to be invited to their care meeting to uphold their rights and for residents to know their own plan of care. New York Code Rules Regulations 415.11 (c)(2)(ii) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**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 each resident received proper treatment and assistive devices to maintain vision; and if necessary, must assist the resident in making appointments for one (1) (Resident #99) of one (1) resident reviewed. Specifically, Resident #99's glasses were reported missing on 03/04/2026 to facility staff and the resident was not seen by an eye doctor until it was arranged by the family 05/05/2026. Resident #99 complained that they were unable to see well without their glasses and were unable to read without their glasses. The findings include: The facility policy titled Consultants revised 2/2023 documented the facility used outside resources to furnish specific services provided by the facility. The facility arranges for qualified professional personnel to furnish specific services to residents and the facility. Consultant services were utilized in the following area: Optometrist. The facility policy titled Resident Rights and Responsibilities revised 1/13/2025 documented the facility functions on the premise that the service it renders should demonstrate its belief in the dignity and worth of every individual. The objective was to provide the Resident with optimal nursing and psychosocial care. Every effort was made by the Staff to meet the Resident's individual needs and requirements. Resident #99 had diagnoses including cerebral infarction (stroke), congestive heart failure (heart muscle unable to pump blood efficiently) and major depressive disorder. The Minimum Data Set (a resident assessment tool) dated 04/18/2026 documented Resident #99 had moderate cognitive impairments, understands and was understood by others. Ability to see in adequate light (with glasses or other visual appliances) was adequate and Resident #99 utilized corrective lenses. The Minimum Data Set, dated [DATE] documented it was very important for Resident #99 to have books, newspapers and magazines to read. The comprehensive care plan last reviewed 04/21/2026 documented Resident #99's vision was adequate with glasses. Interventions included glasses cleaned/applied daily by resident, glasses worn at own discretion, optometry and ophthalmology consult per order. Goal documented Resident #99 will not have signs/symptoms of decreased vision as evidence by ability to continue to read/recognize family/staff through next review. Kardex Report (guide used by staff to provide care) as of 05/10/2026 documented glasses cleaned/applied daily by resident, glasses worn at own discretion, and monitor for vision changes. Leisure Time Activities: interests include reading large print books, reading magazines. Review of progress notes dated 03/04/2026 through 04/29/2026, revealed there was no documented evidence that Resident #99 had missing glasses. A document provided by the facility titled Schedule of residents to be seen by Optometrist dated 04/03/2026 documented thirty-three residents for visits. Resident #99's name and purpose of visit was documented as missing glasses. A line was drawn through Resident #99's name and n/a noted in remarks. An email provided by the facility date sent 04/06/2026 at 12:45 PM from Social Worker #2 to the Medical Records Manager documented that Resident #99's family was eagerly waiting for the appointment (eye doctor on 04/03/2026). Social Worker #2 documented that they were not aware of Resident #99 being ?unavailable'. They documented the family would be upset to wait another month. An email provided by the facility dated 04/06/2026 at 1:03 PM from the Medical Records Manager to Social Worker #2 documented there were many people scheduled for a day, the doctor moves on quickly if someone seems unavailable to them. They stated they did not know for sure, but that Medical Records Clerk was sending the Optometrist service an email to see if there was anything they could do. A progress noted written by the Medical Records Clerk dated 04/30/2026 at 2:21 PM documented an appointment was scheduled on 05/05/26 with an eyecare center at 1:00 PM and that Resident #99's family member was taking them. During an observation and interview on 05/06/2026 at 9:21 AM, Resident #99 was sitting in their wheelchair in their room with a family member. Resident #99 stated they were missing their glasses and needed them for reading and crocheting. Resident #99's family member stated the glasses had been missing for over six weeks<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and the only thing they were told by the facility was that there was an optometrist. They stated they waited for Resident #99 to be seen but they never were. The family member stated they got tired of waiting, so they made Resident #99 an appointment at an eye doctor outside the facility and took the resident themself on 05/05/2026. During an interview on 05/11/2026 at 11:50 PM, Resident #99 stated they enjoy reading and have not been able to read without their glasses. They stated it bothered them not having their glasses, makes it harder for them to see and causes their eyes to hurt. Resident #99's family member stated they did not know if a lost/missing report was completed but that Registered Nurse Unit Coordinator #3, and Social Worker #2 were aware of Resident 99's eyeglasses missing. They stated they had never received any follow-up from the facility related to Resident 99's missing glasses. During an interview on 05/11/2026 at 12:43 PM, Social Worker #2 stated they were aware that Resident #99's glasses were missing and believed a lost/missing report was completed. They stated that the glasses had been missing since the end of March. Social Woker #2 stated that they had spoken to Resident #99's family member once about the missing glasses and about Resident #99 having an appointment to see the in-house eye doctor to get new glasses. Social Worker #2 stated there were email correspondences between Medical Records and them after Resident #99 was not seen by the in-house eye doctor on 04/03/2026. Social Worker #2 stated that Resident #99's quality of life could be affected by not having their glasses. During an interview on 05/11/2026 at 1:38 PM, the Medical Records Clerk stated they were notified on 03/04/2026, through email from Registered Nurse Unit Coordinator #3, that Resident #99's glasses were missing. They stated Resident #99 was added to the in-house eye doctors visit list for 04/03/2026 and they were not seen. The Medical Records Clerk stated they did not know why Resident #99 was not seen on 04/03/2026, just that the visit list indicated, not available. They stated they reached out to the eye doctor via email on 04/06/2026 to inquire about getting glasses for Resident #99 and they never heard back. The Medical Records Clerk stated there was no further follow- up with the eye doctor because they were waiting for a response from them. During a telephone interview on 05/11/2026 at 2:53 PM, Resident #99's family member stated they were not happy that Resident #99 had been without their glasses for two (2) months. They stated prior to today there was no follow up from the facility regarding their missing glasses. They stated they had just spoken with Social Worker #2 about forty-five minutes ago and were asked to bring in a receipt to see what could be done regarding reimbursement. They stated the facility did not offer to arrange any outside appointments for Resident #99 to have their glasses replaced, and that was why they arranged the appointment and took Resident #99 themself. During an interview on 05/11/2026 at 3:47 PM, the Administrator stated they were notified of Resident #99's missing glasses mid to late March and that staff were working with the family to get Resident #99 on list to see in-house eye doctor. They stated Resident #99 was on the eye doctor's list but was not seen. The Administrator stated they did not know why Resident #99 was not seen but that they would have then been placed on the list for the next month. They stated the family did not want to wait for the next eye doctor's visit. They stated the Social Worker followed up with the family today regarding the missing glasses because Resident #99 was just seen by an eye doctor last week. During an interview on 05/12/2025 at 1:08 PM, the Director of Nursing stated every resident should be provided with their assistive devices including glasses. They stated at times glasses can break or go missing, and they would have the resident placed on list to be seen by the Optometrist. They stated an appointment should be made as soon as possible to have glasses replaced for quality of life. They stated they did not believe it should take two (2) months for glasses to be replaced. The Director of Nursing stated they were not aware until last week when Resident #99 went out on the appointment, that their glasses were missing. They stated they were not notified of the circumstances as to why Resident #99's family member took them to see an eye doctor outside of the facility. During an interview on 05/12/2025 at 1:34 PM, Licensed Practical Nurse #7 stated that Resident #99's glasses had been missing for a while. They stated Resident #99 wore them all day and they were their main source for vision. They stated they have not seen Resident #99 reading or<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | crocheting since their eyeglasses went missing. They further stated by Resident #99 not having their glasses limited their ability to do things they enjoy. During an interview on 05/13/2026 at 10:49 AM, Resident #99 stated, I hope the next time I see you I have my glasses so I can see you better. During an interview on 05/13/2026 at 11:33 AM, the Chief Nursing Officer stated they had no policy and procedures specific to vision or eye care. New York Code Rules Regulations 415.11(c)(3)(i) |