STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335656	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haym Solomon Home for the Aged	2340 Cropsey Avenue Brooklyn, NY 11214

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on observations, record reviews and interviews during the Recertification and Abbreviated Survey (NY00341031, NY00353026) conducted from 10/31/2024 to 11/07/2024 the facility did not ensure that injuries of unknown origin were reported immediately but not later than 2 hours after the allegation was made, if the events that cause the allegations involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the New York Department of Health. This was evident for 2 (Resident #144 and #130) of 2 residents reviewed for Abuse out of 38 total sampled residents. Specifically, 1). on 04/29/2024 at 10:00 AM Resident #144 observed with large bluish/purple discoloration to the left breast and yellowish fading discoloration to the chest area that were not reported to the New York State Department of Health in a timely manner, and 2). on 10/23/2023 at 10:00 AM, Resident #130 was observed with a hematoma on left lower leg of unknown origin and the facility failed to report to the State Survey Agency within 2 hours of becoming aware of the injury. The findings are: The facility's policy titled Abuse, Neglect, Mistreatment, Exploitation and Misappropriation of Resident Property - Investigation and Reporting last revised 09/2024 documented that if the Administrator, Director of Nursing, or Grievance Officer has reasonable cause to believe that abuse, neglect, or misappropriation of resident property took place, they will report to the New York State Department of Health and take all necessary corrective action depending on the results of the investigation. The policy did not outline any timeframes for reporting incidents to the Department of Health 1. Resident #144 (NY00341031) was admitted with diagnoses including Non-Alzheimer's Dementia, Old Rib Fractures, and Muscle Wasting. The Quarterly Minimum Data Set assessment dated [DATE] identified Resident #144 as severely cognitively impaired with no physical or verbal behavioral symptoms directed toward others. The Quarterly Minimum Data Set Assessment also documented that Resident #144 required dependent assistance with personal hygiene and toileting hygiene, substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer and toilet transfer with Activities of Daily Living. A Nursing note dated 04/29/2024 at 12:49 PM documented Resident #144 was observed with large bruising involving the left breast. The note also documented that Resident #144 was on Eliquis 2.5 milligram which put Resident #144 at risk for bruise formation. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Full Quality Assurance Report dated 04/29/2024 at 10:00 AM documented that Resident #144 was observed with large bruising involving left breast and bruise on sternum yellowish fading discolorations. The Medical Doctor, Director of Nursing and family were notified. The Registered Nurse Supervisor #1 and Director of Nursing reassessed Resident #144 and observed with a large area of purplish discoloration extended from areola to the lateral side of the left breast, however in the evening, the discoloration had spread to the right breast and right axillary swelling noted. Resident #144 observed with behavior of repetitive uncontrolled movements, moving back and forth, rubbing, and stroking the table with their hands while leaning forward to the table. Resident #144 was on long term Eliquis therapy. The Medical Doctor examined Resident #144 and noted with chest hematoma, upper area of chest with yellow-greenish discoloration, both breasts with dark blue, non-tender and right axillary area with cystic lesion. On 04/30/2024 approximately 7:15 AM, Resident #144 observed with extensive ecchymosis to both breast and sternal area with multiple diffused ecchymosis to upper chest wall. A nursing note titled Resident Transfer Summary dated 04/30/2024 documented Resident #144 was transferred to hospital on 04/30/20204 and left unit at 6:30 PM due to bilateral breast hematoma. The Webform Submission from Nursing Home Facility Incident Report emailed to Director of Nursing documented the incident was submitted to the New York State Department of Health on 05/02/2024 at 13:43. On 11/05/2024 at 11:57 AM, Registered Nurse Supervisor #1 was interviewed and stated they were called on 04/29/2024 at 10:00 AM to Resident #144's room and observed Resident #144 with yellowish-greenish discoloration on chest area and large bruising, purplish discoloration on the left breast. Registered Nurse Supervisor #1 called Certified Nursing Assistant #7 who worked on 04/28/2024 on the 11PM-7AM shift who stated they did not observe any skin discoloration on Resident #144. Registered Nurse Supervisor #1 also stated they did not observe signs of pain, and nobody knew how Resident #144 sustain the discoloration. Registered Nurse Supervisor #1 further stated that by the morning of 04/30/2024 the discoloration had spread to Resident #144's right breast and right arm, so they initiated the report, and the Director of Nursing followed it up and reported to the Department of Health. On 11/05/2024 at 4:19 PM, the Director of Nursing was interviewed and stated they started their investigation on 04/29/2024, and they gathered statements and interviewed staff who had direct contact from 04/27/2024 and 04/28/2024 and documented they did not observe discoloration on Resident #144's skin. The Director of Nursing stated they did not report to the Department of Health because they thought Resident #144 was having blood dyscrasia (a disease or disorder of the blood, bone marrow or lymph nodes) and because Resident #144 was on long term use of Eliquis with a behavior of leaning towards the table. The Director of Nursing stated as the day progressed the discoloration became more pronounced, and Resident #144 was transferred to the hospital on 04/30/2024 at 6:30 PM. On 05/02/2024 at approximately 10:30 AM, the hospital Case Worker called them and reported Resident #144 had right chest wall hematoma which appeared to be trauma and a left acute pelvic fracture. The Director of Nursing stated they reported to Department of Health on 05/02/2024 at 1:43 PM. The Director of Nursing stated there was no witness to how Resident #144 sustained the injury, no report of fall, and they had no evidence to conclude the investigation and that is why they then reported to the Department of Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 2:39 PM, the Administrator was interviewed and stated they were notified of the incident when discoloration and hematoma on the chest wall was discovered. The Administrator also stated it was not reported to Department of Health because they did not know the cause. The Administrator further stated it started as slight discoloration on the chest wall and when they noticed it was spreading further, Resident #144 was sent to the hospital. The Administrator stated since it was a slight discoloration, the facility would do investigation and if they determined that there was an abuse, it must be reported to the Department of Health within two hours. 50894 2. Resident #130 (NY00353026) had diagnoses including Diabetes Mellitus, Non-Alzheimer's Dementia, and Muscle Weakness. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #130 had moderate cognitive impairment and was assessed to require dependent two-person assistance for transfers. The Physician's Order dated 10/20/2023 documented that Resident #130 required two-person dependent assistance using a Hoyer lift for transfers. An Accident/Incident Report dated 10/23/2023, which included Date/Time of Incident as 10/23/2023 at 10:00 AM, documented that Resident #130 was observed with a hematoma and ecchymosis to the outer side of the left lower extremity below the knee. Resident #130 denied falling and stated that it may have happened during a transfer with the Chinese guy but could not describe the allegation more specifically. The Investigation Summary also documented that the facility concluded that there was reasonable cause to believe that the injury occurred on 10/22/2023 at 04:00 PM during a Hoyer lift transfer completed by Certified Nursing Assistant #3 and Certified Nursing Assistant #2, when the resident's left leg encountered a surface during the transfer. The Nursing Home Facility Incident Report Submission documented that the Director of Nursing submitted a report to the New York State Department of Health on 10/25/2023 at 15:55 PM related to Resident #130's hematoma of unknown origin. The Incident Report documented that the Director of Nursing became aware of Resident #130's injury on 10/23/2023 at 10:00 AM. On 11/05/2024 at 04:25 PM, Certified Nursing Assistant #3 was interviewed and stated that they assisted Certified Nursing Assistant #2 with a Hoyer lift transfer for Resident #130 on 10/22/2023. Resident #130 was assigned to Certified Nursing Assistant #2 on this shift but because Resident #130 requires a two person assist for Hoyer lift transfers, Certified Nursing Assistant #3 was assisting as the second person in the transfer. Certified Nursing Assistant #3 also stated that they transferred Resident #130 without issue or concern and that they did not recall Resident #130's leg encountering a surface during the transfer. On 11/05/2024 at 04:33 PM, Certified Nursing Assistant #2 was interviewed and stated that on 10/22/2023, they transferred Resident #130 from their wheelchair to their bed with the assistance of Certified Nursing Assistant #3. Certified Nursing Assistant #2 also stated that they held the resident's legs while Certified Nursing Assistant #3 operated the Hoyer lift. Certified Nursing Assistant #2 further stated that Resident #130's leg did not encounter any surfaces during the transfer. Certified Nursing Assistant #2 stated that they worked with Resident #130 for approximately three hours after the transfer and Resident #130 did not complain to them about leg pain. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 09:46 AM, Licensed Practical Nurse #5 was interviewed and stated that on 10/23/2023 at 02:00 AM, they were providing incontinence care to Resident #130 with Certified Nursing Assistant #5 and observed a hematoma on the resident's left leg. Licensed Practical Nurse #5 also stated that they notified their supervisor of this finding but was unable to recall which supervisor they notified. Licensed Practical Nurse #5 further stated that they were unable to recall if they documented the finding in Resident #130's electronic medical record. An Accident/Incident Report Employee Statement completed by Certified Nursing Assistant #4 on 10/23/2023 documented that Certified Nursing Assistant #4 was providing personal hygiene care to Resident #130 at around 08:30 AM on 10/23/2023 when they observed the hematoma on Resident #130's leg. The statement documented that Certified Nursing Assistant #4 had provided care to Resident #130 on 10/22/2023 and had not observed the hematoma during that shift. On 11/06/2024 at 10:14 AM, the Director of Nursing was interviewed and stated that they became aware of the hematoma on 10/23/2023 at around 10:00 AM and reported it to the New York State Department of Health on 10/25/2023 at 03:55 PM. Certified Nursing Assistant #4 observed the hematoma and notified Registered Nurse Supervisor #2, who immediately notified Medical Doctor #2. Resident #130 was seen by Medical Doctor #2 who ordered an X-ray and CT scan. The X-ray was completed on 10/23/2023 and revealed no fractures. The CT scan was completed on 10/26/2023 and revealed that the injury was a superficial hematoma. The Director of Nursing also stated that when they first became aware of the hematoma, it was an injury of unknown origin. The Director of Nursing further stated that they did not report this to the Department of Health within two hours because they did not know how Resident #130 had developed the injury. The Director of Nursing stated that the facility's typical procedure is to wait until after they receive the results of the X-ray and understand the severity of the injury before they report it, unless the resident verbalizes that someone harmed them. The Director of Nursing also stated that abuse could not be ruled out until the investigation was completed but that at the time of the incident, Resident #130 was not reporting that they had been abused. On 11/07/2024 at 11:18 AM, the Administrator was interviewed and stated that they are not involved in making reports to the Department of Health. The Administrator also stated that the Director of Nursing will make them aware of concerns within the facility, but the responsibility of reporting in a timely manner falls on the Director of Nursing. 10 NYCRR 415.12(h)(1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709 Based on observation, interview, and record review conducted during the Recertification and Abbreviated (NY00330333) survey from 10/31/2024 to 11/07/2024, the facility did not ensure pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was evident for 1 (Resident #3) of 6 residents reviewed for Pain out of 38 sampled residents. Specifically, Resident #3 had a Morphine pump installed in 7/2020, and there was no documented evidence that the cartridge of the pump was changed and or refilled as required every 6 months, or that Resident #3 had been referred to pain management in over 12 months. In addition, there was no documented evidence that Resident #3's had an active order for the morphine pump or as needed pain medication as documented monthly by the physician. The findings are: The facility policy titled Pain Assessment and Management revised 5/2024 stated that residents who experience pain will have a comprehensive assessment of pain and a treatment plan established for his/her pain. The policy also stated ongoing assessment shall be done to evaluate the changing nature of pain as well as the effectiveness of the treatment of the pain. The facility policy titled Infusion Therapy Continuous Ambulatory Delivery Device Patient Controlled Infusion Pump effective 9/22/2023 documented the resident should be under the care of a Licensed physician familiar with intrathecal therapy including indications, contraindications, administration, monitoring, and potential adverse reactions. The policy also documented prescription guidelines should include medication, length and frequency of therapy and parameters for notifying the physicians, order for Narcan, lab work and order for antiemetic as needed. Resident #3 was admitted to facility with diagnosis including Low Back Pain, Rheumatoid Lung Disease, and Benign Prostatic Hyperplasia. The Minimum Data Set assessment dated [DATE] documented Resident #3 was cognitively intact, received a pain medication regime, was not offered pain medication as needed, did not receive nonpharmacological interventions for pain, and experienced moderate pain frequently. The Complaint Intake Form dated 12/21/2023 documented that Resident #3 complained of being in pain due to back surgery, and the facility had not offered them anything other than Tylenol for pain and seemed unconcerned with their pain. On 11/05/2024 at 09:07 AM, Resident #3 was observed lying in bed awake and stated they are reading prayers. Resident #3 also stated they are always in pain but is not sharp pain, because the pump takes care of the sharp pain. Resident #3 pointed to a pump placed in their left lower abdomen, and stated the pump is for lifelong use to help control pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/2024 at 11:40 AM, Resident #3 was interviewed and stated they have a morphine pump in their left lower abdomen which was placed by their private doctor who had cared for them for many years. Resident #3 also stated had they had multiple back surgeries, and the morphine pump takes away most of the pain, but not all the pain and they may have called the Department Of Health on one of those days when they had shooting pain. Resident #3 further stated that every 6 months their doctor comes to the facility to replace the cartridge and they were not sure what dosage of medication they were receiving. Resident #3 stated the pump itself needs to be replaced every 5 or 6 years and they were not sure when it was last replaced. Resident #3 was unable to recall the last time the pump was changed and showed the State Surveyor a card which stated the pump was last refilled in May 2023. Resident #3 stated that their pain today is 6/10 and they are resting in bed as this is what relieves most of their pain now. The Comprehensive Care Plan titled Pain Management Advance Disease process Low Back Pain status post L4 laminectomy and T4-T5 fusion. Resident is on a morphine Pump dated effective 09/25/2016 and last evaluation dated 09/4/2024 with interventions including Morphine pump is pre-set up for automatically delivered morphine, as prescribed, via pump and adjust medications and non-medication interventions. Non-pharmacological interventions to address pain were not documented. The Physician Orders last reviewed 10/16/2024 contained no current orders for a Morphine pump. The Physician orders 6/8/2021 and last reviewed on 10/16/2024 documented Lyrica 50 mg capsule give 1 capsule (50 mg) by oral route once daily at bedtime for low back pain. The Physician Monthly notes dated 10/27/2024, 09/21/2024, 08/17/2024, 08/17/2024, 06/25/2024, 07/23/2024, 06/25/2024 and 05/21/2024 under the section title Active Diagnosis and Plan of Care documented continue with Lyrica, Tylenol as needed, status post intrathecal Morphine pain pump implant replacement, pain management follow up. Review of the medical record revealed no orders for Tylenol as needed or for monitoring of pain. The Nursing progress note dated 5/23/2023 documented as per resident private doctor came today and refilled resident's medication pump. There was no documented evidence that Resident #3's morphine pump was refilled after 05/23/2023. The Pain Management consult dated 10/6/2022 documented pain management follow up. Pain control stable, no changes to pump regimen. Pump refill without complications. Hydromorphone 1.0mg/1ml. Current setting reservoir: 20.0 ml. Duration: 12:00 AM -12:00am 24 hours. 0.2002 mg (0.0083 mg/hour. 24-hour dose: 0.2002 mg/day. Estimated replacement 2029. There was no documented evidence that Resident #3 had been evaluated by pain management since 10/06/2022. Pain monitoring entered on the Medication Administration Record rating of 2/10 for Lyrica to high of 6/10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/2024 at 09:19 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #3 is alert, able to speak all needs, but needs assistance with Activities of Daily Living and they must do everything for them because they have difficulty moving. Certified Nursing Assistant #1 also stated Resident #3 requests a bed bath every morning after which they get dressed for the day. Certified Nursing Assistant #1 further stated that Resident #3 used to go to religious services every day at 8:00 am but now gets ready and sits in the room on the bed and does prayers there. Certified Nursing Assistant #1 stated that Resident #3 does not like to sit in the chair for long periods and will always request to go back to bed, as they prefer to sit on their bed or lie in bed throughout the day, their back hurts if they sit in the chair for too long. Certified Nursing Assistant #1 also stated Resident #3 does not complain of pain during care. Certified Nursing Assistant #1 further stated that Resident #3 has a machine on the left side of their abdomen that beeps at times, and they are not sure what it is. Certified Nursing Assistant #1 further stated they did not ask the nurse about the machine and was not told about it. On 11/05/2024 at 10:19 AM, Licensed Practical Nurse #1 was interviewed and stated Resident #3 is alert and oriented, able to make needs known, and has pain in their back. Licensed Practical Nurse #1 also stated that Resident #3 does not receive pain medication on the day shift and Resident #3 stated when they feel pain, they take a walk on the unit and then lie down. Licensed Practical Nurse #1 further stated that they believe Resident #3 has a morphine pump in their back. Licensed Practical Nurse #1 stated they have nothing to do with the pump, never saw the pump, did not ask Resident #3 about the pump, are not sure how to monitor the pump and was not inserviced about it. Licensed Practical Nurse #1 stated that they ask Resident #3 every day about pain and Resident #3 stated that when they walk, they feel better. On 11/05/2024 at 10:45 AM, Registered Nurse Supervisor #1 was interviewed and stated Resident #3 is alert and oriented, is on Lyrica at bedtime for pain, and takes the pain medication as ordered. Registered Nurse Supervisor #1 also stated that Resident #3 displayed no non-verbal signs of pain and the morphine pump in place relieves the pain. Registered Nurse Supervisor #1 further stated that Resident #3 was seen by psychiatry and is receiving medication based on complaints of pain secondary to spine operation which they had prior to coming to the facility. The Attending Physician manages the Resident #3's pain and Resident #3 refused Tylenol and has been receiving Lyrica since June 2021. Registered Nurse Supervisor #1 stated Resident #3 participates in regular activities and is very vocal about their needs. Registered Nurse Supervisor #1 also stated that Resident #3 has a morphine pump on the right side of their stomach which is replaced every 5 years, and the cartridges are replaced every 6 months by Resident #3's pain management doctor. Registered Nurse Supervisor #1 further stated they were not sure when the cartridge was last replaced. Registered Nurse Supervisor #1 stated that the pump is automatic and is set up to deliver the medications, and there is no monitoring being done for the pump and they are not sure what needs to be done with it. Registered Nurse Supervisor #1 also stated that they have been in the role as supervisor since April 2024, and was aware that the morphine pump was in place. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/05/2024 at 12:47 PM, the Attending Physician for Resident #3 was interviewed via telephone and stated that Resident #3 has a history of refusing care such as lab work and was non-compliant with medical care on occasion such as refusing x-rays after multiple falls. The Attending Physician also stated that they examined Resident #3 recently for complaint of insomnia on 10/24/2024, and Resident #3 was stable and not in pain. The Attending Physician further stated that Resident #3s' morphine pump was placed in 2022 because Resident #3 had a lot of pain due to back surgery, and Resident #3's pain is controlled with Lyrica and Resident #3 does not currently complain about pain. The Attending Physician stated Resident #3 morphine cartridge needs to be replaced every 6 months and they last spoke to Resident #3's private doctor in May 2023 when the pump was last changed, and that physician has since moved to New Jersey and no longer takes Resident #3's insurance. The Attending Physician also stated that they are not sure who the pain management specialist is that will replace the pump. The Attending Physician stated that the facility has monitored Resident #3's pain by checking labs, and through vital signs which have been stable and Resident #3 attends recreational activities and does not stay in their room all the time, so they believe that Resident #3 is not in any pain. The Attending Physician further stated that Resident #3 will be referred to pain management. On 11/05/2024 at 03:35 PM, Licensed Practical Nurse #2 was interviewed and stated they have worked as a float nurse and has administered medications to Resident #3 on multiple occasions. Licensed Practical Nurse #2 also stated that Resident #3 is alert and oriented and able to verbalize all needs. Licensed Practical Nurse #2 further stated that Resident #3 will complain about pain and was prescribed pain and at one point Resident #3 was refusing the patches, and medication was changed to Lyrica at bedtime. Licensed Practical Nurse #2 also stated Resident #3 takes their medication and does not complain of pain. Licensed Practical Nurse #2 further stated that they were not aware that Resident #3 had a morphine pump until today, as this was reported to them by the outgoing day shift nurse. Licensed Practical Nurse #2 stated they never saw the pump, and was not provided in-service on the pump, or on how to monitor a resident on a morphine pump. On 11/05/2024 at 03:38 PM, Licensed Practical Nurse #3 for the evening shift was interviewed and stated they have worked on the unit as a float nurse on multiple occasions in the past but was not aware until today that Resident #3 had a morphine pump in place. Licensed Practical Nurse #3 also stated that Resident #3 is alert and able to make all needs known, is prescribed Lyrica for pain and has voiced no complaint of pain to Licensed Practical Nurse #3. Licensed Practical Nurse #3 further stated they did not receive in-service on the morphine pump or how to monitor a resident on a morphine pump. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 11:24 AM, the Director of Nursing was interviewed and stated they were not aware that Resident #3 had a morphine pump in place and were informed of this by staff on 11/05/2024. The Director of Nursing also stated that they have worked at the facility since January 2023, and they never heard of any complaints about pain for Resident #3 or staff reporting that Resident #3 was in uncontrolled pain in morning report. Care of any resident in pain is discussed in the morning meeting and the resident is referred to pain management for follow up. The Director of Nursing further stated that a resident with a morphine pump should have been discussed in morning report, to ensure they are followed by pain management, and staff is inserviced on the pump. The Director of Nursing stated that after becoming aware of the morphine pump, they realized that Resident #3 had no orders in place for the morphine, or orders in place to monitor the resident. The Director of Nursing also stated they also learned that morphine pump was last refilled in May 2023, and no follow up has been done after that date, and Resident #3 is only receiving Lyrica for pain control at present. The Director of Nursing further stated that if a resident was admitted on a morphine pump, the Director of Nursing would be made aware before the resident is admitted to the facility, would in-service the staff, and ensure that pain management is in place to follow up, as well as physician orders to monitor resident. The Director of Nursing also stated that they had not been informed by the two prior Directors of Nursing that there was a resident with a morphine pump in the facility. 10 NYCRR 415.12