STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335687	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Hills Rehabilitation and Nursing Center	539 Route 22 Purdys, NY 10578

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39308 Based on observation, record review and interview conducted during the recertification survey from 5/9/2024 to 5/16/2024, the facility did not ensure each resident was treated with respect and dignity in an environment that promotes maintenance of their quality of life for 2 of 3 residents (Resident #33 and #105) reviewed for dignity. Specifically, 1, Resident #33 was observed on several occasions wearing socks with name labels that were visible on the outside of both socks, and 2, Resident #105 was noted with photographs depicting the resident in positioning devices on the wall above the head of the bed and visible from the door. The findings are: Policy and Procedure reviewed 4/18/2024 documented all residents have a right to a dignified existence including the right to privacy and confidentiality. 1. Resident #33 was admitted with diagnoses including Alzheimer Disease, Cancer and Depression. The 4/2/24 Quarterly Minimum Data Set documented Resident #33 was rarely/never understood, used a wheelchair, was dependent for upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During observation on 5/10/24 at 11:11 AM, 5/10/24 at 12:45 PM and 5/13/24 at 12:20 PM, Resident #33 was observed in the unit dayroom with pink socks on both feet. Name labels (resident name) were clearly visible on the outside of both socks. During an interview on 5/13/24 at 12:54 PM Staff #8 (Licensed Practical Nurse) stated it was policy that clothing items required name labels, if the facility did the residents laundry. Staff #8 stated that name label/s should be on the inside of socks, to avoid the name being visible to others. Staff #8 stated the visible name labels were a privacy and dignity issue. During an interview on 5/13/24 at 1:05 PM Staff #6 (Certified Nurse Aide) stated Resident #33's socks were labeled on the outside by the laundry staff. Staff # 6 stated that because Resident #33 did not wear shoes, the name labels on the socks were visible. Staff #6 stated they never reported to nursing that the name labels were visible on the outside of Resident #33's socks. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/24 at 1:30 PM Staff #7 (Licensed Practical Nurse Charge Nurse) stated that socks were labeled on the outside because most residents wore foot coverings/shoes. Staff #7 stated Resident #33 did not wear shoes. Staff #7 stated they were not aware that Resident #33's socks were labeled on the outside. Staff #7 stated they saw the concern as this was a dignity issue. 47626 2. Resident #105 was admitted with diagnoses including Dementia, Major Depression, and Glaucoma. The 3/31/24 Minimum Data Set documented Resident #105 had impaired cognition, and was dependent for all activities of daily living. During observation on 05/09/24 at 10:24 AM, 05/13/24 at 12:19 PM, and 05/14/24 at 10:09 AM, there were 2 photographs taped to the wall above Resident #105's bed. The photographs depicted the resident both in the wheelchair and in bed with a positioning device in place. The photographs were visible from the door and could be viewed by the resident's roommate and visitors. During an interview on 05/14/24 at 11:14 AM, Staff #23 (Physical Therapist) stated they posted the photographs behind the bed so the certified nurse aide understood the positioning device and how it should be placed. During an interview on 05/14/24 at 11:25 AM, the Director of Rehabilitation stated the photographs with the positioning devices should have been placed on the inside of the closet door, and should not be on the wall behind the bed. During an interview on 05/14/24 at 11:27 AM Staff #24 (Registered Nurse) stated the certified nurse aides used the photographs on the wall above the bed depicting the positioning device to show them how to use the positioning device. Staff #24 stated it was also on the care guide. 10NYCRR: 415.3 (d)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review and interview conducted during the recertification survey from 5/9/24 to 5/16/24, the facility did not ensure that the call bell system was accessible for 1 of 5 residents (Resident #123) reviewed for environment. Specifically, multiple observations revealed that the call bell designated for Resident #123, was not within the resident's reach. The findings are: Resident #123 was admitted with diagnosis including but not limited to major depressive disorder, overactive bladder, and poly-osteoarthritis. The Risk for Falls care plan dated 4/5/24 documented interventions including answering calls for assistance promptly and call bell to be within reach. The Admission Minimum Data Set (resident assessment tool) dated 4/11/24 documented Resident #123 had intact cognition, required setup with eating, was dependent with toileting and transfers, and required extensive assist with bed mobility. Furthermore, the Admission Minimum Data Set, dated dated dated [DATE] documented Resident #123 had impairments on both sides, upper and lower extremities, and sometimes felt lonely and isolated. On 05/09/24 at 11:12 AM, Resident #123 was observed in their room sitting in their wheelchair on the left side of their bed and the call bell was observed on the right side on the bed. Resident #123 attempted to reach for the call bell and was unable to stretch their left arm across the bed to reach the call bell. Resident #123 stated that that they could not reach the call bell and they needed it closer. Resident #123 stated that staff never leave the call bell within reach and that they needed it close to them so that they would be able to call for assistance. On 05/10/24 at 10:06 AM, Resident #123 was observed in their room sitting in wheelchair and their call bell was observed on the floor behind their wheelchair. Resident #123 stated that when the call bell was on the floor, they could not reach it. During an interview on 05/13/24 at 03:11 PM, Staff #14 (Certified Nurse Aide) stated that Resident #123 could use the call bell and that all residents should have call bells within reach for safety. During an interview 05/15/24 at 12:22 PM, Staff #22 (Registered Charge Nurse) stated that residents must always have calls bells within reach. Staff #22 stated that staff must ensure that the call bells were within resident reach whenever the resident was in their room, whether in bed or in their wheelchair. During an interview on 05/15/24 at 12:47 PM, the Director of Nursing stated that all call bells should be within reach of residents and that it was not acceptable for the call bells to be on the floor or not within resident reach. The Director of Nursing stated that Resident #123 was alert and oriented and was able to make their needs known. The Director of Nursing stated that was even more reason why their call bell should be within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.5(e)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, interview and record review conducted during the recertification survey from 5/09/24-5/16/2024, it was determined that for one (Resident #3) of seven residents reviewed for accidents, the facility did not ensure a comprehensive care plan that included measurable goals and interventions based on resident assessment was provided to maintain the resident's highest practicable physical well-being. Specifically, Resident #3 did not have a care plan in place for self-medication administration. The Findings Are: Resident #3 was admitted with diagnosis including but not limited to bilateral primary osteoarthritis of the knee, polymyalgia rheumatica, and primary osteoarthritis of the shoulder. The Comprehensive Minimum Data Set, dated dated dated [DATE] documented that Resident #3 had intact cognition, required moderate assist with toileting, transfers, and bed mobility, and was independent with eating. On 05/09/24 at 11:08 AM, Resident #3 was observed in their room and multiple tubes of medicated creams (clobetasol [corticosteroid], Lotrimin ultra [antifungal], hemorrhoidal ointment, miconazole nitrate [antifungal] 2% topical cream) were observed on their nightstand. On 05/10/24 at 10:11 AM, Resident #3 was observed in their room. Multiple tubes of medicated creams (clobetasol, lotrimin ultra, hemorrhoidal ointment, and miconazole nitrate 2% topical cream) were on the resident's nightstand. Resident #3 stated that the creams were left by the nurse and either the nurse applied them, or they applied them. On 05/10/24 at 03:14 PM, Resident #3 was observed in their room. Multiple tubes of medicated creams were on the nightstand. Resident #3 stated that they were in the process of ordering new creams because the applicator was not sanitary. Resident #3 stated that some of the creams were for gynecological problems and stated that the nurses left the creams in their room. On 05/13/24 at 02:54 PM, Resident #3 was observed in their room. Clobetasol cream was observed on the resident's nightstand dated 4/25/24. Resident #3 stated that the nurses previously removed the creams but then gave them back. There was no evidence in the medical record documenting that a self medication administration care plan had been put in place. During an interview on 05/10/24 at 04:00 PM, the Assistant Director of Nursing stated that creams should never be left in a resident's room, unless an order for self-application was in place. The Assistant Director of Nursing stated that they were not sure if Resident #3 was able to self-apply creams/ointments or if a care plan was in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/24 at 04:09 PM, the Director of Nursing stated that prior to 5/12/24, there was no care plan in place for medication self-administration. During an interview with on 05/15/24 at 12:25 PM, Staff #22 (Registered Charge Nurse) stated that updates to the care plan must be done when a change happens, and that care plans were updated quarterly and as needed. Staff #22 stated that there should be a care plan in place for Resident #3 to self-administer medications. 10 NYCRR 415.11(c)(1)

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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. 43478 Based on observation, record review and interview conducted during the recertification survey from 5/9/24 to 5/16/24, the facility did not ensure 1 of 3 residents (Resident #57), reviewed for positioning, received treatment and care in accordance with professional standards of practice. Specifically, Resident #57 was observed on multiple occasions sitting in their wheelchair without their footrest extender. The findings are: The facility policy titled, Wheelchair and Positioning Devices, reviewed 8/15/2023 documented it was the policy of the rehabilitation department to determine and provide the appropriate wheelchair and positioning devices for residents. Resident #57 had diagnoses which included depression, dementia, and spinal stenosis, The Activities of Daily Living Functioning Care Plan dated 1/24/23 documented the resident required 1-person extensive assistance with locomotion in wheelchair and 2-person dependent assistance with transfers. The Quarterly Minimum Data Set (resident assessment tool) dated 2/25/24 documented Resident #57 had severely impaired, impairment on both upper and lower extremities, and required dependent assistance with activities of daily living including transfers and locomotion. The 3/11/24 physician's order for physical therapy documented evaluate footrests, resident's feet were not staying on footrests. The 3/12/24 occupational therapy note documented footrest extender placed / adjusted on bilateral leg rests with positive effect. Maintaining bilateral feet on footrests. On 5/9/24 at 10:33 AM, Resident #57 was observed in their wheelchair in the second-floor day room. Resident #57's feet were observed on the floor. Resident #57 was observed grimacing when the Assistant Director of Nursing repositioned their feet onto the wheelchair footrests. On 5/9/24 at 12:42 AM, Resident #57 was observed in the first floor dining room eating lunch with their guardian. Resident #57's feet were observed on the floor, not on their wheelchair footrests. On 5/9/24 at 12:43 AM during an interview, the resident's guardian stated the staff were supposed to put a device on Resident #57 wheelchair footrests, so their feet don't fall off the wheelchair footrests. On 5/10/24 at 11:02 AM, Resident #57 was observed sitting in their wheelchair in the second-floor day room, with no footrest extender in place to their wheelchair footrests. On 5/10/24 at 11:05 AM, a footrest extender was observed on the floor in Resident #57 room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 12:30 PM during an interview, Staff #4, (Registered Nurse) stated they were aware that Resident #57 should have a footrest extender in place to their wheelchair footrests, but they were not aware that the resident did not have the footrest extender in place on 5/9/24 and 5/10/24. On 5/13/24 at 12:38 PM during an interview, Staff #5 (Certified Nurse Aide) stated they were responsible for the resident's care on Thursday 5/9/24. They stated they were aware that the resident required a footrest extender to their wheelchair footrests, but they forgot to apply it on Thursday 5/9/24. They stated they did not tell the nurse that it was not in place. On 5/13/24 at 1:28 PM during an interview, the Assistant Director of Nursing stated it was the certified nurse aide's responsibility to apply the footrest extender when they transfer the resident to their wheelchair. They stated the nurses were responsible to supervise the certified nurse aides. On 5/13/24 at 2:37 PM during an interview, the Director of Rehab stated the footrest extender was added to prevent the resident's feet from sliding off their wheelchair footrests. On 5/14/24 at 1:10 PM during an interview, Staff #11 (Certified Nurse Aide) stated they were responsible for the resident's care on Friday 5/10/24. They stated they were not aware that the resident required a footrest extender to their wheelchair footrests. They stated they floated to the unit and were not a regular on the unit. They stated they did not see the footrest extender in the resident's room. 10NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47626 Based on observation, record review and interview conducted during the recertification survey from 5/9/2024 to 5/16/2024, the facility did not ensure that residents received treatment and services to prevent pressure ulcers for 2 of 8 residents (Residents #105 and #33) reviewed for pressure ulcers. Specifically, 1)Resident #105 was observed without a thigh cushion to off load their heels as ordered by the physician, and 2) Resident #33 who was assessed at high risk for pressure ulcers was observed on multiple occasions with their right heel resting on the metal wheelchair foot rest. The findings are: 1. Resident #105 was admitted with diagnoses which included dementia, depression, and glaucoma. The physician order dated 3/5/2024, documented during supine (lying on back) in bed put heels up cushion under thighs, and black skill care abductor-contracture cushion between lower legs and feet, except for during skin care and hygiene. The Braden Scale completed on 3/25/2024 documented the resident was a moderate risk for pressure ulcers. The Annual Minimum Data Set (an assessment tool) dated 3/31/24 documented Resident #105 had impaired cognition, was dependent with all activities of daily living, was at risk for pressure ulcers, and had no pressure ulcers. During observation on 05/10/24 at 9:52 AM and 05/14/24 at 10:11 AM, Resident #105 was lying in bed on their back. There was no abductor pillow between the legs and feet; there was no cushion under the thighs and the heels were not elevated off the mattress. The under thigh cushion was observed on the chair in the room. The care plan titled Skin integrity: At risk for Skin Breakdown with a 5/7/24 review date, documented interventions during supine in bed included a heels up cushion under thighs and black skil care abductor-contracture cushion between the lower legs and feet except for skin care and hygiene. The May 2024 certified nurse aide care guide documented to off load heels. During an interview on 05/14/24 at 11:35 AM, Staff #25 (Certified Nurse Aide) stated they normally used the positioning devices and off loaded the heels when Resident #105 was in bed. Staff #25 stated they did not know why the positioning cushion was not there today. Staff #25 stated sometimes the resident kicked off the positioning devices. During an interview on 05/16/24 11:15 AM, Staff #7 (Licensed Practical Nurse Manager) stated the resident needed their heels to be offloaded because the resident was at high risk for pressure ulcers. Staff #7 stated the certified nurse aide should off load the resident's heels. If the resident was not tolerating it they should let the nurse know. Staff #7 stated they were not aware the resident had been kicking off the positioning cushion. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39308 2. The facility policy and procedure titled Skin Integrity/Prevention of Pressure Ulcers with a 12/13/23 review date documented the policy was intended to serve as a guideline for the prevention of pressure ulcers in high risk residents/ decrease the risk of pressure ulcers and included encourage/assist with mobility in bed and in wheelchair. Resident #33 was admitted with diagnoses including Alzheimer Disease, Cancer and Depression. The 3/19/24 physician order documented physical therapy evaluation and treatment to assess and provide positioning device to both lower extremities when in bed due to the resident crossing both lower extremities, at risk for skin breakdown. The 3/19/24 physical therapy evaluation/treatment plan documented referral plan establish a wearing time and schedule for the knee separator to both lower extremities in bed and out of bed secondary to the resident crossing the lower extremities, placing them at risk for skin breakdown. The 3/27/24 Braden Assessment documented a score of 11(high risk) The 4/2/24 Quarterly Minimum Data Set documented Resident #33 was rarely/never understood, had 1 sided upper and lower functional limitations, used a wheelchair, was dependent for chair to/bed transfers, upper and lower body dressing, putting on/taking off footwear, was at risk for developing pressure ulcers, had no pressure ulcers, and was receiving 5 days of physical therapy. The care plan titled At Risk for Skin Breakdown with a 4/3/24 review date documented interventions including physical therapy/occupational therapy evaluation for appropriate preventive positioning device/s or equipment. The 4/17/24 physical therapy discharge summary documented the resident tolerated the knee separator to both lower extremities when in bed up to 80% of the time. The 4/18/24 physical therapy note documented discontinue from skilled therapy services as of 4/17/24 use knee separator to both lower extremities 8 hours as tolerated in bed. Observation on 5/10/24 at 11:00AM, Resident # 33 was in the unit dayroom/dining room sitting in their wheelchair with both legs elevated and without shoes. The left foot/lower leg was crossed over the right ankle/foot. The heel of the right foot was resting/pressing against the top corner of the metal foot rest. At 11:11 AM the Assistant Director of Nursing adjusted the placement of Resident # 33's sheet. At 11:18 AM Staff # 9 (Licensed Practical Nurse) wheeled Resident #33's wheelchair to a near by table. During the above observation/s there were no attempts to reposition Resident #33's feet/offload the right heel. Observation on 5/10/24 at 12:45 PM, Resident #33 was in the unit dayroom/dining room sitting in their wheelchair with both legs elevated and without shoes. The left foot/lower leg was crossed over the right ankle/foot. The heel of the right foot was resting against the top corner of the metal foot rest. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/13/24 at 11:35 AM, Resident # 33 was in the elevator/sitting in their wheelchair with both legs elevated and without shoes while being escorted by facility staff. The left foot/lower leg was crossed over the right ankle/foot. The heel of the right foot was resting against the top corner of the metal foot rest. Observation on 5/13/24 at 12:20 PM, Resident # 33 was sitting in their wheelchair with both feet elevated and without shoes while being assisted with their lunch meal. The left foot/lower leg was crossed over the right ankle/foot. The inner right foot was pressed against the inner left metal foot rest. The heel of the right foot was pressed against the top corner of the metal foot rest. During an interview on 5/13/24 at 1:05 PM, Staff # 6 (Certified Nurse Assistant) stated if they positioned Resident #33's foot the resident always crossed the left foot over the right foot. Staff #6 stated Resident #33 did not have a foot rest cushion to offload the heels and did not look comfortable. Staff #6 stated that this was the normal position for Resident #33 but they had not discussed/reported the positioning to nursing/therapy. During an interview on 5/13/24 at 1:16 PM Staff #7 (Licensed Practical Nurse Charge Nurse) stated Resident #33 always rested the left leg over the right foot and they were not aware that the right heel was pressing against the metal foot rest. Staff #7 stated Resident #33 was at risk for skin breakdown if the right heel was resting against the metal foot rest. Upon checking the residents positioning at the time of interview, Staff #7 stated the residents right heel and right inner foot were resting on the metal foot rest/s. Staff # 7 stated they did see the concern. During an interview on 5/13/24 at 1:28 PM the Director of Rehabilitation stated both leg rests on Resident #33's wheelchair should elevate evenly and go back down. The Director of Rehabilitation stated that since the wheelchair foot pedals were metal and Resident #33 did not wear shoes they were at risk for areas of pressure. The Director of Rehabilitation stated that if the unit staff had positioning concerns, the unit nurse should reach out to rehabilitation via referral to request an evaluation and the reason for the evaluation. The Director of Rehabilitation stated they would need to make adjustments to Resident #33's wheel chair positioning/ foot rests. 10NYCRR 415.12(c)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 43478 Based on observation, record review, and staff interview during the recertification survey from 5/9/24 to 5/16/24, the facility did not ensure that needed services, care and equipment were provided to assure that a resident with limited range of motion and mobility maintained or improved function based on the resident's clinical condition for 1 of 3 residents (Resident #89) reviewed for position and mobility. Specifically, Resident #89 was observed on 3 occasions without a right resting hand splint in place as ordered by the physician to prevent further contractures. Findings include: The facility policy & procedure titled Splinting reviewed 2/12/24 documented the purpose, indications, treatment procedure, and wearing schedules of splints. Resident #89 had diagnoses which included primary osteoarthritis, non-Alzheimer's dementia, and frontotemporal neurocognitive disorder. The medical note dated 1/11/24 documented Resident #89 was seen for slight swelling to right hand/fingers. Decreased range of motion to the right hand, wrist, and fingers. Minimal swelling noted, no tenderness. Passive range of motion and stretching performed with resistance. The occupational therapy evaluation & plan of treatment for certification period 1/11/24-2/9/24 documented stiffness of right upper extremity. Contracture: functional limitations present due to contracture. Skilled therapy is needed to address possible right hand/digit contractures. Resident #89 noted with guarding/facial grimacing upon range of motion techniques to right hand digits. Skilled occupational therapy services to assess the need for splinting devices and decrease painful condition of upper extremity. The occupational therapy treatment encounter note dated 1/26/24 documented schedule developed to wear resting hand splint at all times and be removed for skin checks/hygiene. Patient and caregiver training included resting hand splint wearing schedule. The physician's order dated 1/26/24 documented apply right resting hand splint to right hand, to be worn at all times, remove for skin checks and hygiene. The Quarterly Minimum Data Set (resident assessment tool) dated 2/16/24 documented the resident had severely impaired cognition, an impairment to the upper extremity on one side, and required dependent assistance with activities of daily living including transfers and locomotion in wheelchair. The care plan titled Activity of Daily Living Function last updated 2/16/2024 documented apply right hand resting splint to right hand to be worn at all times, remove for skin checks and hygiene. On 5/9/24 at 10:36 AM, 5/10/24 at 11:00 AM, and 5/10/24 at 4:07 PM Resident #89 was observed in their wheelchair in the 2nd floor day room. No right resting hand splint was observed. (continued on next page)

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Salem Hills Rehabilitation and Nursing Center	539 Route 22 Purdys, NY 10578

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 12:25 PM during an interview, Staff #3, (Certified Nurse Aide) stated that on 5/9/24, they did not apply the resident's right hand resting splint because it was dirty and needed to be cleaned. They stated they did not tell the nurse. On 5/13/24 at 12:30 PM during an interview, Staff #4, (Registered Nurse) stated they were not aware that Resident #89 was not wearing their right hand resting splint on 5/9/24. Staff #4 stated that on Friday at approximately 12:00 PM, the Assistant Director of Rehabilitation took the resident's resting hand splint to be washed and did not bring a replacement device. On 5/13/24 at 1:28 PM during an interview, the Assistant Director of Nursing stated they were not aware that Resident #89 did not have the right hand resting hand splint in place on Thursday 5/9/24. On 5/13/24 at 1:38 PM during an interview, the Assistant Director of Rehabilitation stated they removed the right handing resting hand splint from Resident #89 hand on Friday in the early afternoon to be washed. They stated they did not apply a replacement device in the interim, and stated they should have applied a replacement device for Resident #89's contracture management. On 5/13/24 at 2:37 PM during an interview, the Director of Rehabilitation stated Resident #89's right hand resting hand splint was issued for decreased range of motion and contracture to the resident's right hand, and to prevent further contracture. 10NYCRR: 415.12(e)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on observation, interview, and record review conducted during the recertification and abbreviated survey (NY00323734) from 5/9/24 to 5/16/24, the facility did not ensure adequate supervision was provided and that the resident's environment remained as free of accidents hazards as possible for 3 of 7 residents (Residents #89, #72, and #3) reviewed for accidents. Specifically,1) Resident #89 did not receive 1:1 supervision as per plan of care, resulting in a fall, 2) Resident #72 had multiple oral medications and eye drops (left by nursing) in their room on a dementia unit with twelve residents with wandering behaviors, and 3) Resident #3 had medicated creams (left by nursing) in their room on a dementia unit with twelve residents with wandering behaviors. The findings are: The facility policy and procedure, titled Accident Prevention/Falls last revised 12/15/2023 documented it was the policy of the facility to provide adequate supervision, assistance, and assistive devices to prevent accidents. 1. Resident #89 was admitted with diagnoses including but not limited to non-Alzheimer's dementia, anxiety disorder, and mood affective disorder. The Quarterly Minimum Data Set (an assessment tool) dated 8/16/23 documented severely impaired cognition. The resident required 1-person limited assistance with ambulation. The care plan titled Risk for Falls documented on 9/3/23 the resident had a fall and sustained a hematoma (solid swelling of clotted blood) to the left side of the forehead and was sent to the emergency room . The 9/4/23 care plan note documented the resident was placed on 1:1 upon return from the emergency room . The 9/5/23 care plan note documented the resident was to remain on 1:1 observation for 2 more days. The Incident / Accident Report dated 9/5/23 documented, 'resident identified as at risk for incident /accident due to dementia, self-care deficit, history of falls dependent with activities of daily living'. The incident / accident report documented an unwitnessed fall at 10:35 PM. On 5/15/24 at 4:25 PM during an interview, the Director of Nursing stated Resident #89 was on 1:1 supervision upon return from the hospital on 9/4/23 after a fall and was supposed to be on 1:1 supervision for 3 days from 9/4/23 to 9/7/23. The Director of Nursing stated that when Resident #89 had another fall on 9/5/23, the resident was on 1:1 supervision, but the certified nurse aide who was providing 1:1 supervision had stepped away from Resident #89. The Director of Nursing stated that the Registered Nurse and Licensed Practical Nurse Supervisor had educated the certified nurse aide who was assigned to provide 1:1 supervision of Resident #89 not to leave Resident #89 unsupervised, and to ask for assistance or relief if needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 at 4:30 PM during an interview, Staff #21 (Registered Nurse) who was on duty 9/5/23 at the time of Resident #89 fall stated the certified nurse aide who was assigned to do 1:1 supervision for Resident #89 had stepped away from the resident and when they returned to the resident's room they found the resident on floor of their room. The Registered Nurse stated the certified nurse aide who was assigned to do 1:1 supervision of Resident #89 had been educated to stay with the resident at all times and to ask for assistance or relief if they needed to step away, but the certified nurse aide had not asked for assistance or relief. On 5/16/24 at 8:20 AM during an interview, Staff #13 (Licensed Practical Nurse Supervisor) stated they were on duty on 9/5/2023 on the 3-11 evening shift. They stated the certified nurse aide who was assigned to 1:1 supervision of Resident #89 had stepped out of the resident's room. They stated the certified nurse aide who was assigned to 1:1 supervision of Resident #89 had been educated by them and by the Registered Nurse on duty not to leave the resident unsupervised at any time, and to ask for relief if needed. On 5/16/2024 at 8:30 AM during an interview, Staff #17 (certified nurse aide) who was assigned to 1:1 supervision of Resident #89 stepped out of Resident #89 room. They stated they did not ask another staff for assistance or for relief prior to leaving the room. They stated the registered nurse on duty had explained to them not to leave Resident #89 alone, and to ask for assistance or relief if needed. 48847 2. The facility policy titled Medication Administration dated 1/02/2019 and reviewed on 03/12/2024 documented the goal was to ensure safe and accurate medication administration, to stay with the resident until medication was swallowed, and to never leave medication at the bedside. Resident #72 was admitted with diagnosis including but not limited to Alzheimer's disease, major depressive disorder, and shared psychotic disorder. The Quarterly Minimum Data Set (resident assessment tool) dated 4/17/23 documented that Resident #72 had severely impaired cognition, required extensive with toileting, limited assistance with transfers, was independent with eating and bed mobility and had no behaviors or rejection of care. The care plan titled Cognitive Patterns; Dementia dated 8/21/21 documented staff will remind resident to maintain daily schedule, offer resident simple choices, provide cues and assistance as needed. On 05/09/24 at 10:32 AM, Resident #72 was observed in their room. Two almost full bottles of Latanoprost eye drops were observed on the resident's bed side table. One bottle was filled on 11/7//23 and the other was filled on 3/21/24. On 05/10/24 at 09:57 AM, Resident #72 was observed in their room sitting in a chair. There were two medicine cups containing multiple oral medications, and 2 almost full bottles of Latanoprost eyedrops were observed on the bed side table. Resident #72 stated they didn't know when the medications were put on their table and stated they did not know when to take them. Resident #72 stated they took them when they felt like it. They're only vitamins. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/10/24 at 03:28 PM, Resident #72 was observed in their room. One medicine cup with multiple oral medications was observed on the bedside table (Seroquel (antipsychotic) 2.5 mg, Seroquel 12.5 mg, Aldactone (water pill) 25 mg, folic acid (vitamin) 1 mg, Diltiazem (blood pressure medicine) CD 240 ER 24 hr, Lasix (water pill) 40 mg, Eliquis (blood thinner) 5 mg x 2, gabapentin (anticonvulsant) 100 mg, Atorvastatin (cholesterol medication) 20 mg, and Aricept (dementia medication) 5 mg) and Latanoprost (eye drops). On 05/10/24 at 03:35 PM, the Assistant Director of Nursing was observed removing the oral medications from Resident #72's bed side table and at 3:40 PM provided the sureveyor a list with names for the medications that had been removed from the residents room. On 05/10/24 at 04:00 PM, the Assistant Director of Nursing stated they were told by Staff #12 (Licensed Practical Nurse) that the medications were left in the room unattended due to Resident #72 stating they were going to take the medication. The Assistant Director of Nursing stated that it was unacceptable and not good practice for nurses to leave medications unattended at residents' bedside and that Resident #72 was not capable of self-administering medication. The Assistant Director of Nursing stated that the medications found in the Resident #72 room were a mixture of day and evening shift medications and that if a resident refused medications, the nurse should have taken the medications out of the resident's room, written a nurses note, and notified the doctor. During an interview on 05/10/24 at 04:24 PM, Staff #12 (Licensed Practical Nurse) stated they did leave medications in Resident #72's room and that they were aware that medications should never be left unattended. Staff #12 (Licensed Practical Nurse) stated that they should always make sure residents take their medications and if a resident refused, they should report to the charge nurse and document. Review of all Care Plans revealed that there were no care plan in place for self-medication administration. During an interview with on 05/15/24 at 12:25 PM, Staff #22 (Registered Charge Nurse) stated that oral medications should never be left in the residents' rooms because it was a safety hazard and if a resident refused medications, the nurse should re-approach, and if the resident continued to refuse, the nurse should remove medications from the room, document, and make the registered nurse aware. Staff #22 stated that there were a lot of residents who wandered on the unit who may wander into rooms. Staff #22 stated that leaving oral medications in a resident room was a safety issue. During an interview on 05/16/24 at 10:45 AM, the Director of Nursing stated that it was unsafe to leave medications in a resident's room and that the nurse should have ensured that the resident took the medications. The Director of Nursing stated if the resident refused, the nurse should not have left the medications unattended. During an interview on 05/16/24 at 12:41 PM, the Nurse Practitioner stated they were made aware of oral medications being left unattended in Resident #72's room. The Nurse Practitioner stated Resident #72 was not psychologically intact to self-administer their own medications and would not advise them to administer their own medications. The Nurse Practitioner stated that it was harmful to leave medications in the residents' room because there were residents who wandered. The Nurse Practitioner stated Resident #72 did not know what the medications were and would not know how to consume them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #3 was admitted with diagnosis including but not limited to bilateral primary osteoarthritis of knee, polymyalgia rheumatica, and primary osteoarthritis of shoulder. The Comprehensive Minimum Data Set, dated dated dated [DATE] documented that Resident #3 had intact cognition, required moderate assist with toileting, transfers, and bed mobility, and was independent with eating. Review of all Care Plans revealed that there were no care plan in place for self-medication administration. On 05/09/24 at 11:08 AM and 5/10/24 at 10:11 AM Resident #3 was observed in their room. Multiple tubes of medicated creams which included: Clobetasol (steroid), Lotrimin ultra (anti-fungal), hemorrhoidal ointment, miconazole nitrate (anti-fungal) 2% topical cream were observed on their nightstand. Resident #3 stated that the creams were left by the nurse and either the nurse applied the creams, or they applied the creams. On 05/10/24 at 03:14 PM, Resident # 3 was observed with multiple tubes of medicated creams on their nightstand. Resident #3 stated that they were in the process of ordering new creams because the applicator was not sanitary. Resident #3 stated that some of the creams were for gynecological problems and stated that the nurses left the creams in their room. On 05/13/24 at 02:54 PM, Resident #3 was observed in their room. Clobetasol cream was observed on the resident's nightstand dated 4/25/24. Resident #3 stated the nurses previously removed the creams but then gave it back. During an interview on 05/10/24 at 04:00 PM, the Assistant Director of Nursing stated that creams should never be left in a resident's room unless they have an order to self-apply and stated that they were not sure if Resident #3 was able to self-apply creams/ointments. During an interview on 05/10/24 at 04:24 PM, Staff #12 (Licensed Practical Nurse) stated that the creams had been in Resident #3's room for a while and was unsure if there was a physician order to self-apply. During an interview on 05/13/24 at 02:55 PM, Staff #12 (Licensed Practical Nurse) stated that Resident #3 could not self-apply Clobetasol and that the nurses must apply it. Staff #12 (Licensed Practical Nurse) stated that Resident #3 should not have had that Clobetasol in their room and stated that they thought that it had been removed. Staff #12 (Licensed Practical Nurse) stated that creams should be kept locked away in the treatment cart and stated that oral medications were not safe to keep in residents' room due to residents who wander on the unit. During an interview on 05/16/24 at 10:45 AM, the Director of Nursing stated medications and creams must be stored away in the locked medication and treatment carts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 05/16/24 at 12:41 PM, the Nurse Practitioner stated that they didn't know that an official self-medication administration assessment was required and was just going off what the nurses told them about the resident being able to apply their own creams. The Nurse Practitioner stated the first time that they assessed Resident #3 to self-apply creams was on 5/14/24, and when they assessed them, they did not want them to be confused with the two creams (Clotrimazole and Clobetasol) because one is to applied to the Resident's face and the other is for the Resident's vaginal area. The Nurse Practitioner stated that when nursing staff showed them the bags with the creams that were left in the resident's room, they were shocked because the resident could get confused about which cream is for which body. The Nurse Practitioner stated the nurses should have been applying the Clobetasol cream and it should not have been left in the room, due to safety concerns. 10NYCRR 415.12

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on observation, interview, and record review during the recertification survey from 5/9/24 to 5/16/24, the facility did not properly establish and/or maintain an infection prevention and control program designed to provide a safe and sanitary environment. Specifically, 1) the facility did not ensure that an infection surveillance plan based on facility assessment was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks, 2) the facility water management plan had not been reviewed or updated since 2019, and 3) staff did not perform proper hand hygiene during dining for Resident #21. The findings are: The facility policy and procedure titled Infection Control Program dated 1/12/2010 and last reviewed 4/2/2024, documented a surveillance program was essential to the prevention and control of infection within the facility. Its purpose was to detect and record nosocomial infections in order to institute effective control measures. Data was recorded on resident surveillance reports and infection line listing reports. 1. The infection tracking logs documented infections that were being tracked for the month of November 2023. There was no documentation during December 2023 or January through May 2024 that could be reviewed for infection onset dates, signs and symptoms, lab tests/results, isolation, and outbreak potential. During an interview on 5/15/24 at 10:34 AM, the Assistant Director of Nursing Infection Preventionist stated they began tracking infections when resident conditions were discussed during morning report. They stated the facility used the McGreer model for tracking which included symptom-based data. They stated the information was put on a line list but stated they had not done a line list for infections in a long time because they were bogged down with other duties. They stated they were just getting back into it now. The Assistant Director of Nursing stated they knew they should be doing a line list so they could see where infections were in the facility. 2. The facility Legionella water management plan dated December 16, 2019, documented implementation of the plan was intended to prevent disease and injury associated with potable water systems in buildings. Emphasis was on preventing Legionella infection and other clinically significant environmental source pathogens. During an interview on 5/16/24 at 11:13 AM the Facility Engineer stated they were responsible for the program and updates to the environmental risk assessments. The Engineer stated they did not know the water management plan needed to be reviewed annually. The Engineer stated nothing changed so they did not think it needed to be reviewed yearly. During an interview on 5/16/24 at 10:30 AM the Administrator stated they were aware the water management plan needed to be updated annually and the Engineer was responsible for the assessment and updating the water management plan. The Administrator stated they did not know why it had not been done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39308 3. The policy and procedure titled Hand Washing with a review date of 4/25/24 documented hands must be washed before passing trays/handling food, and during performance of duties. Resident #21 was admitted with diagnoses including but not limited to Type 2 Diabetes Mellitus, Parkinson's Disease, and Alzheimer Dementia. The Annual Minimum Data Set (a resident assessment tool) dated 03/24/24 documented Resident #21 had a Brief Interview of Mental Status score of 99, indicating the resident was unable to complete the interview, and received set up assistance for eating. The 1/19/24 care plan titled Activities of Daily Living intervention documented limited assistance x 1 for feeding. During a 5/13/24 at 12:01 PM observation Resident #21 was in the unit dining room sitting in a wheelchair. Staff #10 (Physical Therapist) repositioned Resident #21's chair away from the table and began to perform lower extremity exercises. At 12:06 PM, Resident #21's meal tray was placed on the table in front of them. At 12:10 PM, Staff #10 completed the lower extremity exercises and reattached Resident #21's wheelchair leg/foot rests. Staff #10 then repositioned Resident #21's chair to face the table. Without washing or sanitizing their hands, Staff #10 touched and opened Resident #21s bread packet, and utensil packet. Staff #10 asked the resident if they wanted a clothing protector, and Staff #10 went to get a clothing protector and placed it on the resident. Staff #10 without washing or sanitizing their hands opened the milk carton and held the opened straw. During an interview on 5/13/24 at 2:50 PM, Staff #10 stated they were aware of the facility infection control policy and stated infection control was always reviewed with staff. Staff #10 stated that they had missed washing their hands and could have run to the sink. Staff #10 stated that before touching food/assisting with meal tray set up, hands should be washed, and they needed to develop that habit. 10NYCRR 415.19