STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335694	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Health Care Facility L L C	801 Gazzola Blvd East Patchogue, NY 11772

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observations, record review, and interviews during the Recertification Survey initiated on 11/20/2024 and completed on 11/26/2024, the facility did not ensure the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. This was identified for two (Resident #242 and Resident #293) of two residents reviewed for Choices. Specifically, 1) Resident #242 was observed with the inhalers and nasal spray medications at their bedside during the initial tour and the resident stated they self-administered their inhaler medications. There was no documented evidence that Resident #242 was assessed to self-administer their medications. 2) Resident #293 was observed with the inhalers and a nasal spray medication at their bedside during the initial tour. There was no documented evidence that Resident #293 was assessed to self-administer their medications. The finding is: The facility's Self Administration of Medications policy and procedure last revised on 11/23/2021, documented that Residents have a right to be involved in all aspects of their care including self-administration of medications if the interdisciplinary team deems it clinically appropriate. Each resident and family member as applicable, is given a detailed explanation of the medications that they may self-administer, the reason for the medication, what to expect, and possible side effects within their cognitive ability to understand. Staff re-evaluates the resident's knowledge by having the resident report their understanding of the information presented to them. The medication shall be stored in a locked drawer or locked compartment under proper temperature conditions. 1) Resident #242 was admitted with the diagnoses of Chronic Obstructive Pulmonary Disease, Fracture of the right tibia (leg bone), and Congestive Heart Failure. Resident #242 did not yet have a completed Admission Minimum Data Set assessment during the recertification survey. The Social Work admission assessment dated [DATE] documented that Resident #242 had a Brief Interview for Mental Status Score of 12, indicating the resident had moderately impaired cognition. The Neurological/Memory care plan dated 11/11/2024 documented Resident #242 had a Brief Interview for a Mental Status Score of 12 and was alert and oriented to person, family, and time. The care plan documented Resident #242 had memory loss and deficit related to some forgetfulness upon admission. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Decision-Making care plan dated 11/11/2024 documented that Resident #242 had an alteration in decision-making skills in new situations. The interventions included medications to be administered by the nurse per the resident's preference. The physician's orders dated 11/11/2024 documented Fluticasone Propionate Hydrofluoroalkane Inhalation Aerosol 110 micrograms per actuation (a corticosteroid nasal spray), inhale 1 puff orally every 12 hours for Chronic Obstructive Pulmonary Disorder. The order was discontinued on 11/14/2024. The physician's orders dated 11/11/2024 documented Albuterol Sulfate Hydrofluoroalkane Inhalation Aerosol Solution 108 (90 Base) micrograms per actuation (bronchodilator), inhale 2 puffs orally every 4 hours as needed for shortness of breath. The order was discontinued on 11/21/2024. The physician's orders dated 11/17/2024 documented Flonase (Fluticasone Propionate-Corticosteroid medication) Allergy Relief Nasal Suspension, 50 micrograms per actuation spray, 1 spray in each nostril one time a day for Cough/Congestion until 11/24/2024. During the initial tour on 11/20/2024 at 12:00 PM, Resident #242 was observed lying in bed with a cast on the left leg. A Flonase nasal spray was observed in a labeled Ziploc bag placed on top of the overbed table at the resident's bedside. Resident #242 stated they self-administer the Flonase nasal spray and were permitted to keep the Flonase at their bedside. Resident #242 stated they also self-administered other inhaler medications, which were also stored in their room, A zip lock bag with the following inhalers was observed on top of the dresser on the left side of the bed: Albuterol Sulfate Hydrofluoroalkane Inhalation Aerosol Solution 108 (90 Base) micrograms per actuation inhaler (bronchodialator), Fluticasone Propionate Hydrofluoroalkane Inhalation Aerosol 110 micrograms per actuation inhaler (Corticosteroid medication), and Anoro Ellipta 62.5 micrograms per actuation inhaler (bronchodialator). A review of the physician's orders revealed there was no physician's order for the use of Anoro Ellipta 62.5 micrograms per actuation inhaler and there was no physician's order to self-administer any medications. A review of the resident's care plan on 11/20/2024 revealed there was no indication that Resident #242 was assessed and approved to self-administer medications. A review of the resident's medical record on 11/20/2024 revealed there was no Nursing Evaluation for Self-Administration form completed for Resident #242. During an observation and interview on 11/20/2024 at 12:12 PM, Licensed Practical Nurse #3 entered the resident's room and confirmed the nasal spray on the overbed table was Flonase. Licensed Practical Nurse #3 stated that the resident preferred the medications to be left at their bedside table. Licensed Practical Nurse #3 then walked over to the resident's dresser and pulled the Ziploc bag with three inhalers. Licensed Practical Nurse #3 stated the bag contained an Albuterol inhaler, Anro Ellipta inhaler, and Fluticasone Aerosol inhaler. Licensed Practical Nurse #3 stated the inhalers and the Flonase nasal spray are usually left in the room with the resident. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/2024 at 12:13 PM, Resident #242 stated they usually leave the inhaler medications on the nightstand closer to their bed. Resident #242 stated they did not have a key for the locked drawer on the nightstand to secure the medications. During an interview on 11/20/2024 at 12:18 PM, Licensed Practical Nurse #3 stated they observed Resident #242 self-administer the Flonase nasal spray at 8:00 AM on 11/20/2024 and that Resident #242 typically self-administers the Flonase and the inhaler medications which are stored in the resident's room. Licensed Practical Nurse #3 the resident did not have a physician's order to self-administer the medications. Licensed Practical Nurse #3 stated they were unaware if the resident had a care plan for self-administration and to store the medications in the room. During an interview on 11/20/2024 at 12:20 PM, Registered Nurse #3 stated there was no care plan or Physician's order for Resident #242 to self-administer their medications. Registered Nurse #3 stated the resident was alert and had requested to self-administer the inhalers. Registered Nurse #3 stated the resident was assessed by them (Registered Nurse #3) to self-administer and deemed able to self-administer. Registered Nurse #3 reviewed the medical record and stated there was no documentation related to self-administration of medication assessment in the resident's medical record. Registered Nurse #3 stated they should remove the medications from the room and store them in the medication cart. During an interview on 11/21/2024 at 2:47 PM, Licensed Practical Nurse #4 stated they completed the intake admission assessment for Resident #242 and added the intervention to the resident's care plan for the nurse to administer the resident's medications because the resident preferred the nurse to administer the medications and did not express a preference to self-administer any medications. During an interview on 11/22/2024 at 11:50 AM, the Director of Nursing Services stated the nursing staff should have completed the Nursing Evaluation for Self-Administration evaluation tool for Resident #242. Resident #242 should have a care plan for self-administration if the nursing staff believed that the resident could provide a detailed explanation of the medications, their purposes, and possible side effects. The Director of Nursing Services stated the nurses are expected to monitor the resident's self-administration and document in the medical record. 44925 2) Resident #293 was admitted with diagnoses including Asthma, Dementia, and Chronic Obstructive Pulmonary Disease. The resident's Minimum Data Set assessment was not yet completed as the resident was recently admitted to the facility. The Social Worker Review for New Admission Residents dated 11/12/2024 documented Resident #293 had a Brief Interview of Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognition. The physician's orders dated 11/11/2024 documented: Fluticasone Propionate Nasal Suspension 50 microgram per actuation (Fluticasone Propionate) 2 spray in each nostril one time a day. The physician's orders dated 11/15/2024 included the following: (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 microgram per actuation, 1 inhalation, inhale orally one time a day for Chronic Obstructive Pulmonary Disease. -Wixela Inhub Inhalation Aerosol Powder Breath Activated 250-50 microgram per actuation, 1 inhalation, inhale orally two times a day for Chronic Obstructive Pulmonary Disease Resident #293 did not have a physician's order to self-administer their medications. The medical record did not indicate that Resident #293 was assessed to self-administer their medications. The Comprehensive Care Plan for Impaired Pulmonary Function documented administering treatment per the physician's order. During the initial tour on 11/20/2024 at 10:12 AM, Resident #293 was present in their room. There were Flonase nasal spray, Incruse Ellipta Inhaler, and Fluticasone Propionate/Diskus inhalers on the resident's bedside table. Resident #293 stated they administer their inhalers themselves and take their time to use the inhalers and the nasal spray. The nurses leave the inhalers in their room on the table and pick them up later. During an interview on 11/22/2024 at 10:41 AM, Licensed Practical Nurse #7 stated they usually stay in Resident #293's room until the medication administration is completed because the resident has to rinse the mouth after using the inhalers. Resident #293 had a Dementia diagnosis and could take multiple doses of inhalers and Flonase nasal spray because of forgetfulness, which is not safe. Licensed Practical Nurse #7 stated on 11/20/2024 while they were administering medications to Resident 293, they got called into another room. Licensed Practical Nurse#7 stated they left the inhalers in the resident's room and went to attend to another resident. During an interview on 11/22/2024 at 11:51 AM, Registered Nurse Unit Manager #6 stated it was not a usual practice for Licensed Practical nurses to leave the inhalers and nasal sprays in the resident rooms. Registered Nurse Unit Manager #6 stated due to Resident#293's diagnosis of Dementia, it was not safe to leave the inhalers and the nasal spray in the resident's room unattended. Registered Nurse Unit Manager #6 stated Resident #293 did not have a physician's order to self-administer their medication. During an interview on 11/22/2024 at 11:50 AM, the Director of Nursing Services stated the residents were not allowed to self-administer their medications without a Brief Interview for Mental Status Score assessment by a social worker. The nurses are supposed to evaluate the resident's capacity to self-administer their medications and develop a care plan for self-medication administration. if the resident was not allowed to self-administer their medications then all medications must be stored in the medication cart; however, if the resident was allowed to self-administer their medications and wanted to keep the medication in their room, the medications must be stored in the locked drawer. The Director of Nursing Services stated Resident#293 was not assessed to self-administer their medications and should not have administered inhalers and nasal spray medications on their own. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/2024 at 9:50 AM, Medical Doctor #1 stated Resident #293 was at risk for taking the inhalers and Flonase multiple times due to Resident #293's cognitive decline and Dementia diagnosis. Medical Doctor #1 stated If the resident had a cognitive decline and was not assessed for self-administration of medication, the nurse should not have left the medications in the resident's room. 10 NYCRR 415.18(e)(1-4)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 11/20/2024 and completed on 11/26/2024 the facility did not ensure each resident received care and services for the provision of parenteral fluids consistent with professional standards of practice, physician orders, and the comprehensive person-centered care plan. This was identified for one (Resident #343) of four residents reviewed for Infection Control. Specifically, Resident #343 was observed on 11/20/2024 with a left arm Midline Intravenous Catheter dressing that was dated 11/01/2024. Additionally, the external Midline catheter length was not measured and recorded as per the physician's orders. The finding is: The facility's policy titled Peripherally Inserted Central Catheter Line/ Midline Care and Treatment last revised on 5/2024, documented that Midline dressing changes are done within 24 hours of new line placement and then every week and as needed. Measure the external catheter length and record the length in centimeters in the Treatment Administration Record. Label the dressing with the date, time, and initials. Resident #343 was admitted with diagnoses that include Retroperitoneal abscess, Methicillin-Resistant Staph Aureus infection (antibiotic-resistant organism), and Acute Respiratory Failure. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. The Minimum Data Set assessment documented Resident #343 had intravenous access and received intravenous medications. The Comprehensive Care Plan titled Intravenous Therapy dated 11/08/2024 documented interventions that included dressing changes and flushing the intravenous catheter as per the facility policy and physician orders. The physician's order dated 11/08/2024 documented that a Registered Nurse is to change the Midline insertion site dressing and measure the external catheter length in centimeters, and date, time, and initial the dressing, every 7 days and as needed. The Medication Administration Record for November 2024 documented that the intravenous Midline insertion site dressing was to be changed weekly and the external catheter was to be measured and documented. The following was identified: -On 11/09/2024 there was no documentation of the intravenous Midline insertion site dressing change or the external catheter measurement. -On 11/16/2024 Registered Nurse Unit Manager #2 documented the intravenous Midline insertion site dressing change was completed; however, the external Midline catheter length was documented as zero. -On 11/23/2024, the Director of Nursing Services documented the intravenous Midline insertion site dressing change was completed; however, external Midline catheter measurements were not documented. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #343 was observed in bed sleeping on 11/20/2024 at 10:10 AM. The resident had an intravenous catheter in their left arm and was receiving intravenous medication. The dressing on the insertion site was dated 11/01/2024. A nursing progress note dated 11/20/2024 at 2:50 PM, written by Registered Nurse Unit Manager #1, documented the Mid-line dressing was changed on 11/20/2024. Resident #343 was observed in bed sleeping on 11/21/2024 at 08:10 AM. The resident had an intravenous catheter in their left arm. The dressing on the insertion site did not indicate a date, initials, or time the dressing was changed. During an interview on 11/21/2024 at 2:39 PM, Registered Nurse Unit Manager #1 stated they changed the Midline insertion site dressing yesterday and forgot to sign and date the new dressing. They also did not document the external Midline catheter measurement. Registered Nurse Unit Manager #1 stated it is important to measure and monitor the external Midline catheter length to determine if the catheter line is moving. Registered Nurse Unit Manager #1 stated the intravenous site dressing should be changed weekly and when they changed the dressing on 11/20/2024, the old dressing was dated 11/1/2024 (indicating the dressing was last changed on 11/1/2024). A nursing progress note dated 11/21/2024 at 4:10 PM, written by Registered Nurse Unit Manager #1, documented that the Midline external catheter measured 13 centimeters. During an interview on 11/25/2024 at 10:24 AM Registered Nurse Unit Manager #2 stated they did the Midline insertion site dressing change on 11/16/2024 and should have documented the Midline external catheter measurement accurately and not a zero. The Midline insertion site dressing should be changed every 7 days, and the catheter length should be measured, and recorded in the Medication Administration Record. The midline insertion site dressing should be dated and initialed when changed. During an interview on 11/25/2024 at 10:50 AM, the Director of Nursing Services stated a Registered Nurse is responsible for measuring the Midline catheter length weekly and changing the Midline insertion site dressing. The dressing should be dated, timed, and initialed. Resident #343's Midline insertion site. The dressing change and measurement should be done weekly by a Registered Nurse and documented in the Medication Administration Record. The Director of Nursing Services stated the Midline catheter was placed at the hospital and the insertion site dressing should have been changed weekly after the resident was admitted to the facility. 10 NYCRR 415.12(k)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review, and interviews during the Recertification Survey initiated on 11/20/2024 and completed on 11/26/2024, the facility did not ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice. This was identified for one (Resident #84) of one resident reviewed for Respiratory Care. Specifically, Resident #84 had a physician's order to continuously receive oxygen therapy via a nasal cannula at 3 Liters per minute. Resident #84 was observed on 11/20/2024, receiving oxygen therapy via a nasal cannula. The nasal cannula was connected to an oxygen tank which was set to deliver oxygen at 3 liters; however, the oxygen tank gauge needle indicated the tank was empty. The finding is: The facility policy titled Oxygen Therapy last revised on 9/2023, documented apply oxygen per physician's order. The clinical staff is to monitor the oxygen tank gauge during care and at 15-minute intervals and notify the nurse if empty. Nurses are to record oxygen usage in supervisors' reports as indicated. Resident #84 was admitted with diagnoses including Chronic Respiratory Failure, Toxic Encephalopathy, and Diabetes Mellitus Type 2. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status as a 12, which indicated moderate cognitive impairment. The Minimum Data Set assessment documented active diagnosis of respiratory failure. The Minimum Data Set assessment documented Resident #84 was on continuous oxygen therapy. The Comprehensive Care Plan for Impaired Pulmonary Function initiated on 9/12/2024 and last reviewed on 10/02/2024, documented interventions that included oxygen administration as per the physician's orders. A physician's order dated 9/12/2024 documented to administer oxygen every shift, continuously, via a nasal cannula at 3 liters per minute. During an observation on 11/20/2024 at 9:40 AM, Resident #84 was asleep in their bed with a nasal cannula applied to their nose. The nasal cannula tubing was connected to an oxygen tank. The oxygen delivery rate was set to 3 liters per minute; however, the oxygen gauge needle (which indicates the amount of oxygen in the tank) indicated the tank was empty and had no oxygen supply. During an observation and interview on 11/20/2024 at 9:43 AM, Licensed Practical Nurse #2 went into Resident #84's room and confirmed that the oxygen tank was empty. Licensed Practical Nurse #2 stated that they were responsible for checking and changing the oxygen tanks. They began their shift at 7 AM; however, they did not go into the resident's room until now. Licensed Practical Nurse #2 stated the Oxygen tanks should be checked by nursing staff each shift and replaced before the tank is empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/2024 at 8:47 AM, Registered Nurse Unit Manager #1 stated nursing staff should conduct rounds at the beginning of their shifts. The rounds involve checking on all residents and inspecting necessary items, such as oxygen tanks. Resident #84's oxygen tank should have been checked by the assigned nurse at the start of their shift, not at 9:43 AM during the medication pass. The nursing staff is responsible for monitoring the oxygen equipment, which includes setting up and changing the oxygen tanks. During an interview on 11/22/2024 at 2:35 PM, Physician Assistant #1 stated that Resident #84 had an order for 3 liters of oxygen therapy per minute to be delivered continuously. The nursing staff is expected to follow this order and if they need to adjust the oxygen flow, they should do so and notify them afterward. Physician Assistant #1 stated the lack of oxygen could cause shortness of breath and a higher heart rate indicating respiratory distress, which may require transferring the resident to the emergency room . During an interview on 11/26/2024 at 8:35 AM, the Director of Nursing Services stated that nurses are responsible for monitoring and changing the oxygen tanks for the residents. The Director of Nursing Services stated Nurses should check the oxygen tanks at the beginning of their shift, during medication pass, and at the end of their shift. The Director of Nursing Services stated nurses should change the oxygen tank as needed. The Director of Nursing Services stated Certified Nursing Assistants can also monitor the oxygen tanks but must inform a nurse when an oxygen tank needs to be changed. The oxygen tanks should be replaced as necessary. 10 NYCRR 415.12 (k)(6)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observation, record review, and interviews during the Recertification initiated on 11/20/2024 and completed on 11/26/2024, the facility did not ensure that all residents received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This was identified for one (Resident #242) of one resident reviewed for Mood and Behavior. Specifically, Resident #242's hospital records indicated that they experienced suicidal ideation and were placed on a three-day suicide watch before admission to the facility. Direct care staff at the facility were not knowledgeable of the resident's recent history of suicidal ideation and did not develop a person-centered plan of care to address the resident's mental health needs based on the resident's psychosocial history. The finding is: The facility's Behavioral Health Services policy dated 11/2016 documented that each resident will receive, and the facility will provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. An initial psychosocial history, assessment, and at least quarterly progress notes which provide information reflective of the resident's status and information helpful to the staff in understanding and caring for each resident will be maintained in the medical record. The psychosocial history shall include relevant historical information as appropriate and necessary. The hospital discharge narrative dated 11/6/2024 documented on 11/3/2024 patient expressed suicidal ideations to staff. Patient was placed on suicide watch with one-to-one observation. A psychiatry consultation was obtained. Patient required a three-night stay. On 11/4/2024 Patient was re-evaluated by psychiatry and was deemed not to have the capacity to make their own medical decisions. On 11/5/2024, the Psychiatrist re-evaluated and reported the patient no longer required one-to-one and was stable for discharge. Resident #242 was admitted with the diagnoses of Chronic Obstructive Pulmonary Disease, Fracture of the right tibia (leg bone), and Congestive Heart Failure. Resident #242 did not have a completed Admission Minimum Data Set assessment during the recertification survey. The Comprehensive Care Plan dated 11/11/2024 documented that Resident #242 had an alteration in psychosocial well-being, mood, and behavior patterns related to functional decline. Interventions included to encourage the resident to express emotions in a safe environment; establish trust with the resident, facilitate access to community resources; provide a calm, quiet, and reassuring environment; respect and listen to the expression of feelings; and monitor mood/behavior for change. The care plan did not indicate the resident's history of Depression and recent suicidal ideation. The physician's order dated 11/11/2024 documented Quetiapine (an antipsychotic medication) 50 milligrams, give one tablet by mouth at bedtime for sleep. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 11/11/2024 documented Oxycodone Hydrochloride (an opioid medication) tablet 5 milligrams, give two tablets (total of 10 milligrams) by mouth every four hours as needed for severe pain. The Social Work admission assessment dated [DATE] documented Resident #242 had a Brief Interview for Mental Status assessment score of 12, indicating the resident had moderately impaired cognition. Social Worker #1 documented that Resident #242 presented with sadness during admission and verbalized being upset with the current placement. There was no indication of the resident's history of depression or recent suicidal ideation while at the hospital. The Physician Admission Evaluation dated 11/12/2024 documented the resident denied suicidal ideations and thoughts of hopelessness. The Physician documented the resident's psychiatric/mental state was alert, and oriented with normal affect. The resident had impaired judgment and insight at times. The plan included a psychiatric re-evaluation for Quetiapine one tablet at bedtime. There was no indication of the resident's history of depression or suicidal ideation while at the hospital. The Psychiatry Care Note dated 11/16/2024 documented Resident #242 reported a history of lifelong Depression and denied current Depression symptoms. Resident #242 reported Anxiety secondary to being at the facility and they spoke with their Physician about wanting Xanax (an anti-anxiety medication). The resident denied suicidal or homicidal ideation and manic (a psychiatric state of elevated energy) symptoms. The resident declined the use of antidepressants at this time and was only interested in using Xanax. The nursing staff reported that the resident had a depressed mood. The resident reported they had a previous psychiatric diagnosis but could not remember what it was and that they used to be seen at a community mental health clinic for medication management but the clinic closed two years ago. The resident was currently on Quetiapine 50 milligrams one tablet by mouth at bedtime for sleep. The Psychiatric Nurse Practitioner documented Resident #242 presented with adjustment disorder with mixed Anxiety and depressed mood. The physician's order dated 11/17/2024 documented Alprazolam (Xanax) oral disintegrating 0.25 milligrams, give one tablet by mouth every 8 hours as needed for Anxiety for 14 days. The order was discontinued on 12/1/2024. The Physician's progress note dated 11/18/2024 documented Resident #242 reported worsening Anxiety and a headache that wraps around the forehead. The resident verbalized that the smaller dose of Xanax was somewhat effective, but not enough. Resident #242 requested an increase in Xanax dosage and wanted as well as Vicodin (an opioid medication). The Physician's progress note dated 11/19/2024 documented Resident #242 continued to report worsening anxiety with a consistent headache. The resident reported the current dose of Xanax is not helpful. The Xanax dosage was increased to 0.5 milligrams today with recommendation for a psychiatric evaluation. The physician's order dated 11/19/2024 documented Alprazolam oral 0.5 milligrams, give one tablet by mouth every 8 hours as needed for Anxiety for 14 days. The order was discontinued on 12/3/2024. (continued on next page)

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	335694	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour on 11/20/2024 at 12:00 PM, Resident #242 was observed lying in bed with a cast on the left leg. A small clear plastic cup was observed at the overbed table with a peach-colored tablet inside the cup. Resident #242 stated the tablet was Xanax. Resident #242 stated the nurse just came in and administered the Xanax tablet at 11:50 AM, but the resident wanted to take the Xanax with Oxycodone, which is why the nurse left the medication at the bedside and told the resident they would come right back; however, the nurse did not return with the Oxycodone yet. Resident #242 stated that they refused to take the Xanax tablet without the Oxycodone. During an observation and interview on 11/20/2024 at 12:12 PM, Licensed Practical Nurse #3 stated they administered Xanax 0.5 milligram tablet to Resident #242 at 11:30 AM. Licensed Practical Nurse #3 stated Resident #242 was upset because the resident wanted Oxycodone to be administered with Xanax. Licensed Practical Nurse #3 entered the resident's room and confirmed that the tablet stored in the plastic cup was Xanax. Licensed Practical Nurse #3 told the resident I saw you put the pill in your mouth. Resident #242 denied spitting out the medication back into the cup. Licensed Practical Nurse #3 told Resident #242 that they could overdose if they took the Oxycodone with the Xanax. Licensed Practical Nurse #3 stated the resident was insisting on taking Oxycodone with Xanax even though they had already taken the Oxycodone at 8:00 AM. During an interview on 11/20/2024 at 12:20 PM, Registered Nurse #3 stated they were regularly assigned to Resident #242 since their admission and none of the medication nurses reported Resident #242 was cheeking (when someone hides pills, liquids, or films in their cheek to avoid swallowing them) their Xanax medication and storing it for later use. Registered Nurse #3 stated the medication nurse should stay with the resident to confirm the resident swallowed their medications and Xanax should not be left at the bedside. During an interview on 11/21/2024 at 2:47 PM, Licensed Practical Nurse #4 stated they completed Resident #242's intake admission assessment on 11/11/2024. Licensed Practical Nurse #4 stated they reviewed the hospital record and were aware that the resident had suicidal ideation at the hospital and was one-to-one observation. The resident was cleared by the hospital Psychiatrist and that is why they (Licensed Practical Nurse #4) did not alert the facility staff about the resident's suicidal ideation history. During an interview on 11/21/2024 at 3:25 PM, Social Worker #1 stated they were covering for the assigned social worker on 11/11/2024 and completed the admission intake for Resident #242. Social Worker #1 stated the resident denied Depression, a mental health history of Depression, or suicidal ideation. Social Worker #1 stated they were not aware that the resident had a recent history of suicidal ideation in the hospital. Social Worker #1 stated they only reviewed the Patient Review Instrument and Screen information from the hospital when completing the Social Worker Admission evaluation. Social Worker #1 stated if they read that the resident had suicidal ideation on 11/3/2024 in the hospital, they would have recommended increased monitoring and referred the resident for psychiatric care sooner. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/2024 at 3:43 PM, Social Worker #2 stated they were the assigned Social Worker for Resident #242 and had first met the resident on 11/19/2024 to discuss the resident's care plan. During the meeting, Resident #242 requested a higher dose of Xanax for Anxiety. Social Worker #2 stated they did not know about Resident #242's suicidal ideation while at the hospital on 11/3/2024. If they knew, they would have requested mental health services immediately and implemented increased monitoring. Social Worker #2 stated they did not know that on 11/20/2024, Resident #242 cheeked the Xanax to combine it later with Oxycodone. Social Worker #2 stated they would have met with the resident and offered psychotherapy services with the Psychologist. During an interview on 11/22/2024 at 9:14 AM, Physician Assistant #1 stated they reviewed the hospital records and were aware of the resident's suicidal ideation. Physician's Assistant #1 stated that the resident was fine and upon their initial assessment, the resident denied suicidal ideation. Physician's Assistant #1 stated they did not document the resident's recent history of suicidal ideation in the medical record because they wanted to be careful as to what they documented in the chart. Physician Assistant #1 stated they referred and informed the Psychiatrist about the resident's history of suicidal ideation. Physician Assistant #1 stated they were aware of Resident #242's attempts to save Xanax medication and the nursing staff implemented a two-person approach during medication administration. During an additional interview on 11/22/2024 at 9:30 AM, Licensed Practical Nurse #3 stated did not know of Resident #242's recent history of suicidal ideation while at the hospital. Licensed Practical Nurse #3 stated if they knew, the nursing team would have implemented suicide prevention measures such as placing the resident closer to the nursing station and implementing hourly rounds while the resident was in their room. Licensed Practical Nurse #3 stated the resident did not verbalize suicidal ideation; however, the resident was drug-seeking and frequently asked for Oxycodone every two hours and wanted to consume Xanax with Oxycodone. During an additional interview on 11/22/2024 at 9:37 AM, Registered Nurse #3 stated they did not know of Resident #242's recent history of suicidal ideation in the hospital. Registered Nurse #3 stated if they had been made aware, the resident's room would have been cleared for potentially hazardous items such as wires and the resident would have been placed on 15-minute checks. Registered Nurse #3 stated they would have encouraged the resident to come out to the lounge area instead of staying in their room all the time and they would have made a referral for a Psychologist to meet with the resident to address their mental health needs. During an interview on 11/22/2024 at 11:50 AM, the Director of Nursing Services stated they would not expect suicide prevention measures to be put in place at the facility because Resident #242 was cleared by psychiatry at the hospital. The Director of Nursing Services stated if the nursing team noticed new signs and symptoms of Depression, they would have psychiatry come in to evaluate the resident. The Director of Nursing Services stated they did not know what the Social Services should look for when conducting the admission evaluation. The Director of Nursing Services stated that the nurses, who were aware of the resident's repeated [medication] cheeking behavior, should have alerted the Social Work team to meet and discuss the care plan with the resident. 10 NYCRR 415.12(f)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on observations, record review, and interviews during the recertification initiated on 11/20/2024 and completed on 11/26/2024, the facility did not store all drugs and biologicals in secured locked compartments. This was identified for two (Resident #242 and Resident #293) of two residents reviewed for Choices. Specifically, 1) Resident #242 was observed with multiple inhalers and a nasal spray medication at their bedside during the initial tour. There was no nurse observed in the vicinity. 2) Resident #293 was observed with multiple inhalers and a nasal spray medication at their bedside. There was no nurse observed in the vicinity The finding is: The facility's Medication/Treatment Labeling and Storage policy and procedure last revised on 7/2013 documented resident's medications/treatments are to be placed in the proper storage area; medication room, supplies in a clean utility room, treatment cart, or medication cart. Controlled substances are stored in double-locked cabinets in the locked medication room. 1) Resident #242 was admitted with the diagnoses of Chronic Obstructive Pulmonary Disease, Fracture of the right tibia (leg bone), and Congestive Heart Failure. Resident #242 did not have a completed Admission Minimum Data Set assessment during the recertification survey. The Social Work admission assessment dated [DATE] documented Resident #242 had a Brief Interview for Mental Status assessment score of 12, indicating the resident had moderately impaired cognition. The decision-making care plan dated 11/11/2024 documented that Resident #242 had an alteration in decision-making skills in new situations. The interventions included medications to be administered by the nurse per the resident's preference. The physician's orders dated 11/11/2024 documented Fluticasone Propionate Hydrofluoroalkane Inhalation Aerosol 110 micrograms per actuation, inhale 1 puff orally every 12 hours for Chronic Obstructive Pulmonary Disorder. The order was discontinued on 11/14/2024. The physician's orders dated 11/11/2024 documented Albuterol Sulfate Hydrofluoroalkane Inhalation Aerosol Solution 108 (90 Base) micrograms per actuation, inhale 2 puffs orally every 4 hours as needed for shortness of breath. The order was discontinued on 11/21/2024. The physician's orders dated 11/17/2024 documented Flonase (Fluticasone Propionate) Allergy Relief Nasal Suspension, 50 micrograms per actuation spray, 1 spray in each nostril one time a day for Cough/Congestion until 11/24/2024. A review of the physician's orders revealed there was no physician's order for Anoro Ellipta 62.5 micrograms per actuation inhaler. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the initial tour on 11/20/2024 at 12:00 PM, Resident #242 was observed lying in bed with a cast on the left leg. A Flonase nasal spray in a labeled Ziploc bag was observed on top of the overbed table at the resident's bedside. Resident #242 stated they self-administer the Flonase nasal spray and were permitted to keep the Flonase beside them. Resident #242 stated they also self-administered inhaler medications, which were also stored in the room. A zip lock bag with the following inhalers was observed on top of the dresser on the left side of the bed: Albuterol Sulfate Hydrofluoroalkane Inhalation Aerosol Solution 108 (90 Base) micrograms per actuation inhaler (bronchodilator), Fluticasone Propionate Hydrofluoroalkane Inhalation Aerosol 110 micrograms per actuation inhaler (Corticosteroid medication), and Anoro Ellipta 62.5 micrograms per actuation inhaler (bronchodilator). During an observation and interview on 11/20/2024 at 12:12 PM, Licensed Practical Nurse #3 entered the resident's room and confirmed the nasal spray on the overbed table was Flonase. Licensed Practical Nurse #3 stated that the resident preferred the medications to be left at their bedside table. Licensed Practical Nurse #3 then walked over to the resident's dresser and pulled the Ziploc bag with three inhalers. Licensed Practical Nurse #3 stated the bag contained an Albuterol inhaler, Anro Ellipta inhaler, and Fluticasone Aerosol inhaler. Licensed Practical Nurse #3 stated the inhalers and the Flonase nasal spray are usually left in the room with the resident. During an interview on 11/20/2024 at 12:13 PM, Resident #242 stated they usually leave the inhaler medications on the nightstand closer to their bed. Resident #242 stated they did not have a key for the locked drawer on the nightstand to secure the medications. During an interview on 11/20/2024 at 12:18 PM, Licensed Practical Nurse #3 stated they observed Resident #242 self-administer the Flonase nasal spray at 8:00 AM on 11/20/2024 and that Resident #242 typically self-administers the Flonase and the inhaler medications which are stored in the resident's room. Licensed Practical Nurse #3 the resident did not have a physician's order to self-administer the medications. Licensed Practical Nurse #3 stated they were unaware if the resident had a care plan for self-administration and to store the medications in the room. During an interview on 11/20/24 at 12:20 PM, Registered Nurse #3 reviewed the medical record and stated they could not locate any documentation of the assessment deeming the resident able to self-administer their medications. Registered Nurse #3 stated they should remove the medications from the room and store them in the medication cart. During an interview on 11/22/24 at 11:50 AM, the Director of Nursing Services stated medications should be stored in the medication cart even when a resident is cleared to self-administer the medication. The Director of Nursing Services stated if the team feels a medication can be left in the room, it should be stored away in a locked drawer and the resident should have a key to access the medications. 44925 2) Resident #293 was admitted with diagnoses including Asthma, Dementia, and Chronic Obstructive Pulmonary Disease. The resident's Minimum Data Set assessment was not yet completed as the resident was recently admitted to the facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Worker Review for New Admission Residents dated 11/12/2024 documented that Resident #293 had a Brief Interview of Mental Status score of 11, which indicated the resident had moderately impaired cognition. The physician's orders dated 11/11/2024 documented: Fluticasone Propionate Nasal Suspension 50 microgram per actuation (Fluticasone Propionate) 2 spray in each nostril one time a day. The physician's orders dated 11/15/2024 included the following: -Incruse Ellipta Inhalation Aerosol Powder Breath Activated 62.5 microgram per actuation, 1 inhalation, inhale orally one time a day for Chronic Obstructive Pulmonary Disease. -Wixela Inhub Inhalation Aerosol Powder Breath Activated 250-50 microgram per actuation, 1 inhalation, inhale orally two times a day for Chronic Obstructive Pulmonary Disease Resident #293 did not have a physician's order to self-administer their medications. During the initial tour on 11/20/2024 at 10:12 AM, Resident #293 was present in their room. There were Flonase nasal spray, Incruse Ellipta Inhaler, and Fluticasone Propionate/Diskus inhalers on the resident's bedside table. Resident #293 stated they administer their inhalers themselves and take their time to use the inhalers and the nasal spray. The nurses leave the inhalers in their room on the table and pick them up later. During an interview on 11/22/2024 at 10:41 AM, Licensed Practical Nurse #7 stated they usually stay in Resident #293's room until the medication administration is completed. Resident #293 had a Dementia diagnosis and could take multiple doses of inhalers and Flonase nasal spray because of forgetfulness, which is not safe. Licensed Practical Nurse #7 stated on 11/20/2024 while they were administering medications to Resident 293, they got called into another room. Licensed Practical Nurse#7 stated they left the inhalers in the resident's room and went to attend to another resident. During an interview on 11/22/2024 at 11:51 AM, Registered Nurse Unit Manager #6 stated it was not safe to leave the inhalers and the nasal spray in the resident's room unattended. During an interview on 11/22/2024 at 11:50 AM, the Director of Nursing Services stated if the resident was not allowed to self-administer their medications then all medications must be stored in the medication cart; however, if the resident was allowed to self-administer their medications and wanted to keep the medication in their room, the medications must be stored in the locked drawer. During an interview on 11/25/2024 at 9:50 AM, Medical Doctor #1 stated Resident #293 was at risk for taking the inhalers and Flonase multiple times due to Resident #293's cognitive decline and Dementia diagnosis. Medical Doctor #1 stated If the resident had a cognitive decline and was not assessed for self-administration of medication, the nurse should not have left the medications in the resident's room. 10 NYCRR 415.18(e)(1-4)