STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335724	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silvercrest	144 45 87th Avenue Jamaica, NY 11435

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on interview and record review conducted during the Recertification and Complaint survey (NY00325467) from 12/12/2024 to 12/19/2024, the facility did not ensure that it promoted and facilitated resident self-determination through the support of resident choice. This was evident for 1 (Resident #103) of 5 residents reviewed for Choices. Specifically, bathing preference was not obtained and not provided in accordance with Resident #103's wishes. The findings are: The facility's policy and procedure titled Performing Activities of Daily Living (ADL) revised 9/1/2022 documented all residents will be provided a shower or bath, with assistance as necessary as least twice per week, unless otherwise specified by resident's plan of care. Resident #103 was admitted to the facility with Diabetes Mellitus, Hyperlipidemia, and Hypertension. The Annual Minimum Data Set, dated dated dated [DATE] documented that it was very important for Resident #103 to choose between tub bath, shower, bed bath or sponge bath. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #103 had intact cognition, was independent with eating, and required substantial assistance for showering. On 12/13/2024 at 2:02 PM, Resident #103 stated they have been in the facility for about 4 years and had only been receiving bed baths. Resident #103 also stated that they requested to be showered multiple time but was still receiving bed baths. The Comprehensive Care Plan titled Activities of Daily Living dated 12/1/2023 reviewed 10/2/2024 documented that Resident #103 required substantial assistance for shower/bathing. The care plan did not document Resident #103's bathing preferences. The Resident Nursing Instructions revised 7/15/2024 documented Resident #103's bathing type was bed bath or shower, and the bathing schedule was Wednesdays and Saturdays during the 3:00 PM to 11:00 PM shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services note dated 9/17/2024 documented that Resident #103 reported not having a shower in 4 years and that the Administrator was made aware of it. Review of progress notes dated 9/17/2024 to 12/16/2024, there was no documentation that resident's shower preference was addressed. The Certified Nursing Assistant Documentation Record for 11/1/2024 to 12/16/2024 documented Resident #103 received a bed bath on 3 (11/2/2024, 11/9/2024, 11/27/2024) out of 9 opportunities in November of 2024. Bathing was not performed for Resident #103 on 11/6/2024, 11/13/2024, 11/16/2024, 11/20/2024, 11/23/2024 and 11/30/2024. Resident #103 received a bed bath on 3 (12/4/2024, 12/7/2024, 12/11/2024) out of 4 opportunities in December of 2024. Bathing was not performed on 12/14/2024. Review of the medical record from 11/1/2024 to 12/16/2024 contained no documented evidence that Resident #103 refused bathing on the other scheduled bathing days. On 12/19/2024 at 3:24 PM, Certified Nursing Assistant #6 stated that Resident #103 had been in the facility for a long time and had always received bed baths on Wednesday and Saturdays during the 3 PM to 11 PM shift. Certified Nursing Assistant #6 also stated that Resident #103 required a special bariatric shower chair which was not available. Certified Nursing Assistant #6 further stated that all staff including nurses knew Resident #103 needed a special bariatric shower and there was no chair yet. On 12/19/2024 at 4:25 PM, Certified Nursing Assistant #7 stated that Resident #103 was admitted to the facility about 4 years ago and was having a lot of pain initially and was not able to get out of bed so received bed baths at that time. Certified Nursing Assistant #7 also stated that there was no shower chair that was appropriate for Resident #103's size; therefore, giving a shower was not an option. Certified Nursing Assistant #7 further stated that Resident #103 was only getting bed baths due to lack of equipment and them not being able to get out of bed. On 12/16/2024 at 4:21 PM, Social Worker #2 stated Resident #103 has a wheelchair that they utilize for ambulation, but the chair was not able to fit through the entryway to the shower room. Social Worker #2 also stated that they had planned to purchase a special chair that is appropriate for Resident #103's size and able to fit through the entry. Social Worker #2 further stated that they did not know the status of the shower chair and did not know whether or not the chair was ordered. On 12/17/2024 at 9:31 AM, Resident #103's wheelchair was measured at 36 inches wide and was not able to fit through the entry to shower room. On 12/19/2024 at 1:00PM, the Administrator stated that a shower chair Resident #103's was ordered immediately on 12/03/2024 after they were made aware of the problem and they are currently waiting for it to be delivered. On 12/19/2024 at 2:03 PM, the Director of Nursing stated Resident #103 has a history of refusing shower and has been getting bed bath twice weekly as per their staff. The Director of Nursing Resident also stated that upon admission residents select the bathing preferences with showers scheduled twice weekly or bed bath only which can be changed any time as per resident's request. The Director of Nursing was not able to explain why Resident #103 was only provided bed baths. (continued on next page)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.5 (b)(1-3)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51390 Based on observation, record review and interviews conducted during the Recertification and Complaint survey (NY00340617) survey from 12/12/2024 to 12/19/2024, the facility did not ensure that adequate clean linen was provided to facilitate timely care of residents. Specifically, there were multiple complaints of insufficient linen from residents and staff. The findings are: The policy titled Laundry and Linen Management dated 10/13/1998 and revised 09/25/2024 stated that it is the policy of the facility to maintain an adequate supply of clean linen through safe and sanitary laundry procedures. The policy also stated that the Laundry Department will supply a sufficient quantity of linen for proper resident care and comfort. The undated document titled NEW PAR LEVEL documented towel distribution as follows: 2 North 7 AM-3 PM =40, 3 PM -11 PM=30, 11 PM to 7 AM=20 2 South 7 AM-3 PM =40, 3 PM -11 PM=30, 11 PM to 7 AM=25 3 North 7 AM-3 PM =40, 3 PM -11 PM=40, 11 PM to 7 AM=30 3 South 7 AM-3 PM =40, 3 PM -11 PM=40, 11 PM to 7 AM=30 4 North 7 AM-3 PM =40, 3 PM -11 PM=40, 11 PM to 7 AM=26 4 South 7 AM-3 PM =40, 3 PM -11 PM=40, 11 PM to 7 AM=26 5 North 7 AM-3 PM =60, 3 PM -11 PM=60, 11 PM to 7 AM=50 5 South 7 AM-3 PM =60, 3 PM -11 PM=60, 11 PM to 7 AM=50 During the Resident Council meeting held on 12/16/24 at 11:48 AM, 4 of 10 residents complained of insufficient linen which has been an ongoing issue for several months, and stated that they have been told by staff, particularly on weekends, that there is not enough linen, and linen is distributed on a first come, first served basis. On 12/18/24 at 10:51 AM, an interview was conducted with Certified Nursing Assistant #15 who stated that towels are always short, and additional linen has to be requested once or twice a week. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Silvercrest		STREET ADDRESS, CITY, STATE, ZIP CODE: 144 45 87th Avenue Jamaica, NY 11435	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/18/24 at 11:03 AM, an interview was conducted with Certified Nursing Assistant #17 who stated that they are mostly short of towels on the unit and sometimes they run out before they can give care to all the residents on their assignment. Certified Nursing Assistant #17 also stated that daily on their assignment there are at least 2 residents out of 10 scheduled to have a shower and the availability of towels is an issue. When giving showers, they may use 2-3 towels per resident and 1 towel for a bed bath so they would need a minimum of 12 to 14 towels on their shifts. Certified Nursing Assistant #17 further stated that sometimes when they do not want to wait for towels to be brought up, they will use the nightgown that they take off to dry the resident off. On 12/18/24 at 11:37 AM, an interview was conducted with Certified Nursing Assistant #16 who stated that sometimes linen is not available on the unit to enable them to get residents out of bed by 10:30-11:30 every day. Certified Nursing Assistant #16 also stated that many times the linen is not enough, and they have to wait until it comes up from downstairs. On 12/19/24 at 10:25 AM, an interview was conducted with Certified Nursing Assistant #18 who stated that sometimes they have to wait to provide care because there is not enough linen. Certified Nursing Assistant #18 also stated that on their daily assignment they have 2-3 residents that need a shower, and they would use one towel for a bed bath, sometimes two for the shower, and some residents might want three towels if they wash their hair. Certified Nursing Assistant #18 further stated that they are frequently short of towels on the weekend, or the towels are delivered to the unit late so they would try to use washcloths to dry the residents until the towels are delivered to the floor. Certified Nursing Assistant #18 stated that at times they have to ask their peers to share the linen they have so as not to delay caring for the residents and completing their assignment on time. 37787 Resident #12 (NY00340617) was admitted to the facility with diagnoses that include Quadriplegia, Muscle Spasm, Hereditary and Idiopathic neuropathy. The Minimum Data Set assessment dated [DATE] revealed that the resident was cognitively intact. During an interview on 12/16/2024 at 4:17 PM, Resident #12 stated that the facility is always short of clean linen, including sheets, bed savers and towels. Resident #12 further stated that bed savers are being soiled more easily, so more linens are needed to change the beds. Resident #12 further stated that it is impossible for the staff to work without having enough linen. On 12/17/2024 at 1:16 PM, Registered Nurse #3 was interviewed and stated that beds are changed twice a week and as needed. Registered Nurse #3 also stated that when there is a problem with linen on the unit, they call the Director of Housekeeping to ask for more linen. Registered Nurse #3 further stated that sometimes, extra linen might not be available right away, and housekeeping would then call when it is ready. On 12/18/2024 at 12:47 PM, Certified Nursing Assistant #3 was interviewed and stated that not having enough supplies is something that happens often. Certified Nursing Assistant #3 also stated that most of the time, for 10 residents, they receive 8 towels, sometimes only 6 so they have to use clothing to dry off the residents. Certified Nursing Assistant #3 further stated that if there are not enough pads to put on the bed, the evening shift will continue, if linen becomes available on the evening shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Silvercrest		STREET ADDRESS, CITY, STATE, ZIP CODE 144 45 87th Avenue Jamaica, NY 11435	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/24 at 11:53 AM, Certified Nursing Assistant #13 was interviewed and stated that the facility is always short of linen on the morning shift. Certified Nursing Assistant #13 also stated that sometimes, they might find some sheets, towels, or bed savers left over from the night shift so use that to start. On 12/19/24 at 01:10 PM, an interview was conducted with the Director of Environmental Services who stated that par levels are determined with the interdisciplinary team, and they deliver according to what the need is. The Director of Environmental Services also stated that they believe the current par level list was developed as of August 2024. The Director of Environmental Services further stated that currently linen is being done in-house, and prior to August an outside company used to deliver the linen. The Director of Environmental Services stated that linens are packaged and delivered to the units 10 minutes prior to the start of shift, and they were not aware that there was an issue with late linen delivery, or of short linen supply. On 12/19/24 at 01:51 PM, an interview was conducted with the Director of Nursing who stated that they attended the Resident Council meetings when residents voiced a concern that there was not enough linen. The Director of Nursing also stated that they feel that since laundry is now being done in house, there is more control and no longer an issue with the linen supply. The Director of Nursing further stated that par levels are determined based on the acuity and the needs of the residents and were adjusted within the last month or so. the Director of Nursing stated that they have noticed that staff hoard towels, so they did environmental rounds and adjusted the par levels so try to stop that practice. On 12/19/24 at 02:30 PM an interview was conducted with the Administrator who stated that par levels were established when they started doing laundry in house. We monitored how many towels were being returned and we adjusted at one point, and we thought the issue was resolved. The Administrator also stated they did sporadic audits to determine what was being returned and we found that linen was being returned unused. The Administrator further stated that the audit did not include whether additional linen was sent to the unit and remained at the end of the shift. 10 NYCRR 415.5(h)(3)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observation, record review, and interviews conducted during the Recertification and Abbreviated (NY00350202) survey from 12/12/2024 to 12/19/2024, the facility did not ensure a resident was free from physical abuse. This was evident for 1 (Resident #173) of 3 residents reviewed for Abuse out of 38 total sampled residents. Specifically, Resident #173 reported that on 08/03/2024, at approximately 04:00 AM, Certified Nurse Aide #1 was rough with them while providing care, and Certified Nurse Aide #1 did not stop their actions, continued with the task while Resident #173 continued to express their discomfort, and then Certified Nurse Aide #1 yelled at Resident #173. The finding is: The facility policy titled Abuse Prevention/Prohibition dated 08/16/22 stated that all residents will be screened for potential abuse, an investigation will be conducted, the Administrator is responsible for completing the investigation report. The policy also stated that any person having reasonable cause to believe that an older adult is in need of protective services may report such information to the local provider, and all interventions will be documented in the resident's medical record. Resident #173 had diagnoses which include Quadriplegia, Chronic Respiratory Failure, Depression, and Tracheostomy Dependency. The Annual Minimum Data Set assessment dated [DATE] documented that Resident #173 was cognitively intact and was dependent and required 2 person assist when performing Activities of Daily Living. The Occurrence Report dated 08/3/2024 documented that, on 08/03/24 around 10:00 AM, the resident's husband, who was visiting stated that the Certified Nurse Aide treated the resident roughly and yelled at the resident while they were providing care. The Social Worker and the Nurse Manager met with the resident and the resident communicated the same complaint. Resident was assessed and there were no physical signs of injury. Emotional support was provided, and the resident was assured that the Certified Nurse Aide #1 will no longer provide care to the resident. Certified Nurse Aide #1 was immediately removed from assignments and the New York State Department of Health was notified. The facility concluded that the complaint was thoroughly investigated and concluded that resident's plans of care were to be two person assist and needed two person when staff are providing care, but the Certified Nurse Aide #1 did not follow the plan of care for the resident. The report also documented that there was probable evidence of abuse, neglect or mistreatment and the Department of Health was notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Services note dated 08/3/2024 documented that they were notified by another social worker that the resident complained that during night care, the Certified Nurse Aide #1 was rough and yelled at her. The Social Services note also documented that they interviewed the resident via computer communication device, and the resident re-stated that during care the Certified Nurse Aide #1 was rough while turning her and yelled at her to not stiffen her legs up. The Social Worker evaluated the resident with the resident's spouse at the bedside along with the primary nurse. The entire body was examined, no visible sign of injury was noted (redness, swelling, bruising or abrasions). The resident denied pain or discomfort. The resident was crying and said they were upset about the incident. Emotional support and comfort provided to the resident and spouse. Resident also re-assured that Certified Nurse Aide #1 will no longer be assigned to their care, resident became calm and was thankful. On 12/13/24 at 04:28 PM, Resident #173 was observed in their room, alert and awake. Resident #173 was not able to verbalize and communicated via a computer communication device. During interview Resident #173 stated that at around 4:00 AM on that day, Certified Nurse Aide #1 appeared angry during care and seemed angry with Resident #173 and began to turn them roughly and slammed their right leg up and down. Resident #173 also stated that Certified Nurse Aide #1 was rough as they changed their incontinence brief and despite them trying to communicate that they were very uncomfortable during care, the Certified Nurse Aide #1 did not stop what they were doing. Resident #173 further stated that they felt so terrible, and they began to cry and the following morning they told their spouse what had occurred. Resident #173 stated that they had been cared for by Certified Nurse #1 in the past, and while they did not want Certified Nurse Aide #1 to get into any trouble, they spoke up because they did not want this situation to happen to someone else who may not be able to speak up for themselves. The Resident Certified Nurse Aide Documentation History Detail dated July 2024 to August 2024 documented Resident #173 received dependent care with bathing, bed mobility, dressing, personal hygiene, turning and positioning and that Certified Nurse Aide #1 provided care for Resident #173 on 08/02/2024. The Comprehensive Care Plans Behavior and Abuse/Victim initiated on 10/15/2022, revised on 8/3/2024 documented that the resident will be free from abuse/neglect and will not exhibit aggressive behavior to others and the resident will not be afraid to report abuse. Interventions included observe resident for physical findings, unusual skin marks, discoloration, ecchymosis, and report promptly, provide emotional support, re-educate staff on abuse/neglect and behavior management as needed. On 12/17/24 at 03:41 PM, an interview was conducted with the Director of Nursing, who stated that all staff are given training on abuse annually and as needed. The Director of Nursing also stated that they always do reminders and re-education about abuse. The Director of Nursing stated that they did not speak directly to Resident #173 as Resident #173 cries easily cry so they limit care to regular staff who are familiar with her. The Director of Nursing further stated that they did not view the incident as abuse and recommended that 2 persons should provide care for Resident #173 as it might be challenging and place the resident at risk of injury with only one staff person. The Director of Nursing stated that there was no sign of injury however Resident #173 was very fearful and fragile. The Director of Nursing further stated that Certified Nurse Aide #1 did not go there with the intent to cause harm, but they did not follow the plan of care for Resident #173. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 09:53 AM, an interview was conducted with Certified Nurse Aide #1 who stated that they have provided care to Resident #173 for over a year. Resident #173 is nonverbal however, they can make facial gestures and one can tell if Resident #173 is happy or not. Certified Nurse Aide #1 also stated that throughout the night on 08/03/24, they visited Resident #173 on several occasions, and around late midnight they cleaned and changed the resident's brief. Certified Nurse Aide #1 stated that they performed care alone and Resident #173 is not able to turn themselves, so they used the bed sheet and placed a pillow on Resident #173's upper back to turn them. Certified Nurse Aide #1 also stated that they did not make eye contact with Resident #173 during care and did not see any signs that Resident #173 was experiencing any discomfort. Certified Nurse Aide #1 further states that they were suspended for 8 days and received in-services. On 12/18/24 at 10:42 AM, an interview was conducted with Registered Nurse #2 who stated that they work per diem, had provided care for Resident #173 in the past, and had not received any complaints about staff from them. Registered Nurse #2 also stated that they assessed Resident #173 after the incident, and Resident #173 communicated with them using a computer device and stated that Certified Nurse Aide #1 was rough on them while providing care. Registered Nurse #2 further stated that Resident #173 was crying, and it took a while for Resident #173 to stop crying. 10 NYCRR 415.4 (b)(1)(i)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18881 Based on record review and interviews conducted during the Recertification Survey and Complaint Survey (NY00361139, NY00361002, NY00353498, NY00348185 and NY00340617) from 12/12/2024 to 12/19/2024, the facility did not ensure sufficient nursing staff were available to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1). par levels documented in the Facility Assessment did not reflect actual weekend staffing levels. 2). interviews with members of the Resident Council, reflected ongoing concern about staffing levels at the facility, 3). five of eleven complaints investigated during the survey involved staffing concerns, and 4). interviews with other residents and staff reflected stafffing concerns. This was evident during the Sufficient and Competent Nurse Staffing Task. The findings include but are not limited to: The facility policy and procedure titled Nursing Coverage Plan last revised on 05/03/2024 documented that the Staffing Plan for Nursing Services reflects specific service needs to meet resident care and organizational needs. Evaluation of floor/unit specific needs is an ongoing process and ensures that staffing skill mix reflects the resident care needs. The policy also documented that the purpose was to ensure that the staffing needs of the facility are met. 1. The Facility Assessment last updated on 09/02/2024 documented a facility capacity of 320 residents with a staffing plan for weekdays, weekends, and holidays and by shift distributed as follows: Daily Staffing: Monday to Friday 7 AM-3 PM Shift: 1 Registered Nurse Manager per floor. Unit 2 North- 2 Registered Nurses and 4 Certified Nursing Aides. Unit 2 South- 2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 3 North -2 Licensed Practical Nurses, 4 Certified Nursing Aides. Unit 3 South -2 Licensed Practical Nurses, and 4 Certified Nursing Aides. Unit 4 North- 2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 4 South -1 Registered Nurse, 2 Licensed Practical Nurses, and 4 Certified Nursing Aides Unit 5 North-4 Registered Nurses, 5 Certified Nursing Aides. Unit 5 South-4 Registered Nurses, 5 Certified Nursing Aides. Monday to Friday 3 PM-11 PM Shift: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Unit 1 Registered Nurse Supervisor for the entire facility Unit 2 North- 2 Registered Nurses and 4 Certified Nursing Aides. Unit 2 South- 2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 3 North -2 Licensed Practical Nurses, and 4 Certified Nursing Aides. Unit 3 South -2 Licensed Practical Nurses, and 4 Certified Nursing Aides. Unit 4 North- 1 Registered Nurse and 1 Licensed Practical Nurse, and 4 Certified Nursing Aides. Unit 4 South- 1 Registered Nurse, 2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 5 North-4 Registered Nurses, 5 Certified Nursing Aides. Unit 5 South-4 Registered Nurses, 5 Certified Nursing Aides. Monday to Friday 11 PM-7 AM Shift: 1 Registered Nurse Supervisor for the entire facility Unit 2 North- 2 Registered Nurses, and 2 Certified Nursing Aides. Unit 2 South- 1 Licensed Practical Nurse and 3 Certified Nursing Aides. Unit 3 North -1 Licensed Practical Nurse, and 3 Certified Nursing Aides. Unit 3 South -1 Licensed Practical Nurses, and 3 Certified Nursing Aides. Unit 4 North- 1 Registered Nurse and 1 Licensed Practical Nurse, and 3 Certified Nursing Aides. Unit 4 South- 1 Registered Nurse,2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 5 North-4 Registered Nurses, 4 Certified Nursing Aides. Unit 5 South-4 Registered Nurses, 4 Certified Nursing Aides. The Facility Assessment also outlined coverage for Weekends and Holidays, which did not specify which shift the staffing pattern was for, as follows: Unit 2 North- 2 Registered Nurses, and 2 Certified Nursing Aides. Unit 2 South- 1 Licensed Practical Nurse and 4 Certified Nursing Aides. Unit 3 North -1 Licensed Practical Nurse, and 3 Certified Nursing Aides. Unit 3 South -1 Licensed Practical Nurses, and 4 Certified Nursing Aides. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silvercrest	144 45 87th Avenue Jamaica, NY 11435

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Unit 4 North- 2 Licensed Practical Nurses, and 3 Certified Nursing Aides. Unit 4 South- 1 Registered Nurse, 2 Licensed Practical Nurses and 4 Certified Nursing Aides. Unit 5 North-4 Registered Nurses, 5 Certified Nursing Aides. Unit 5 South-4 Registered Nurses, 5 Certified Nursing Aides. An asterisk indicated that there would be 2 Registered Nurse Managers on the day shift, and 1 Registered Nurse Manager on the evening and night shift. Review of the weekend staffing for October 2024 reflected the following: On 10/05/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 4S. On 10/05/2024 on the 11 PM to 7 AM shift there was a shortage of 1 Certified Nursing Assistant on Unit 2S, 3S, 4S, 5N and 5S, 1 Licensed Practical Nurse on Unit 4N and 4S, and 1 Registered Nurse on Unit 5S. Total shortage of staff was 6 Certified Nursing Assistants, 2 Licensed Practical Nurses, and 1 Registered Nurse in a 24-hour period with no replacement. On 10/06/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5N and 5S. On 10/06/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5N, 5S, 1 Licensed Practical Nurse on Unit 4N and 1 Registered Nurse on unit 5S. On 10/06/2024 on the 11 PM to 7 AM shift there was a shortage of 1 Certified Nursing Assistant on Unit 3S, 4S, and 5S, and 1 Registered Nurse on Unit 5S. Total shortage of staff was 7 Certified Nursing Assistants, 1 Licensed Practical Nurse, and 2 Registered Nurses in a 24-hour period with no replacement. On 10/12/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Certified Nursing Assistant and 1 Registered Nurse on Unit 5S. On 10/12/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 2N, 5N, 5S, 1 Licensed Practical Nurse on Unit 2S and 3N, and 1 Registered Nurse on Unit 3S and 5S. Total shortage of staff was 4 Certified Nursing Assistants, 2 Licensed Practical Nurses, and 3 Registered Nurses in a 24-hour period with no replacement. On 10/13/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Licensed Practical Nurse on Unit 4S and 1 Registered Nurse on Unit 5N. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/13/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5N and 5S. Total shortage of staff was 2 Certified Nursing Assistants, 1 Licensed Practical Nurse, and 1 Registered Nurse in a 24-hour period with no replacement. On 10/19/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5N and 5S. On 10/19/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5S, and 1 Registered Nurse on Unit 5N and 5S. On 10/19/2024 on the 11 PM to 7AM shift there was a shortage of 1 Certified Nursing Assistant on Unit 4S, 5N, 5S, and 1 Registered Nurse on 5S. Total shortage of staff was 6 Certified Nursing Assistants and 3 Registered Nurses in a 24-hour period with no replacement. On 10/20/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Licensed Practical Nurse on Unit 4N. On 10/20/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Licensed Practical Nurse on Unit 4N. On 10/20/2024 on the 11 PM to 7 AM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5N and 5S, and 1 Registered Nurse on 5S. Total shortage of staff was 2 Certified Nursing Assistants, 2 Licensed Practical Nurses, and 1 Registered Nurse in a 24-hour period with no replacement. On 10/26/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5S, 1 Licensed Practical Nurse on Unit 4N and 1 Registered Nurse on Unit 5N and 5S. On 10/27/2024 on the 7 AM to 3 PM shift there was a shortage of 1 Certified Nursing Assistant on Unit 5S, and 1 Licensed Practical Nurse on Unit 4N and 4S. On 10/27/2024 on the 3 PM to 11 PM shift there was a shortage of 1 Licensed Practical Nurse on Unit 4N. On 10/27/2024 on the 11 PM to 7 AM shift there was a shortage of 1 Certified Nursing Assistant on Unit 4S, 5N and 5S, 1 Licensed Practical Nurse on Unit 4N and 1 Registered Nurse on Unit 5S. Total shortage of staff was 4 Certified Nursing Assistants, 4 Licensed Practical Nurses, and 1 Registered Nurse in a 24-hour period with no replacement. 51390 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During the Resident Council meeting conducted on 12/16/2024 from 11:00 AM to 11:50 AM, 9 of 10 residents reported concerns with staffing. On 12/16/24 at 11:09 AM, Resident #160 stated that they were told there would be 4 Certified Nursing Assistants working on their unit and many times there are less than that. On 12/16/24 at 11:11 AM, Resident #184 stated that when it is short on weekends and holidays they are not able to get out of bed and this happens regularly. Resident #184 also stated that they often have to miss showers on both scheduled days because there is not enough staff. On 12/16/24 at 11:13 AM, Resident #114 stated that they often miss showers missed showers on their scheduled days. Resident #114 also stated that they might start the day with 4 Certified Nursing Assistants and then staff gets pulled to go to another floor or to escort a resident on an appointment. On 12/16/24 at 11:15 AM, Resident #6 stated that the facility only schedules 4 Certified Nursing Assistants most times, so if there are callouts there is shortage. Resident #6 also stated that when the facility receives sick calls from staff, there is a lot of scrambling and asking for staff to stay over which leads to staff being burnt out. 37787 3. Resident #12 (NY00340617) was admitted to the facility with diagnoses that include Quadriplegia, Muscle Spasm, Hereditary and Idiopathic Neuropathy. The Minimum Data Set assessment dated [DATE] revealed that the resident was cognitively intact. During an interview on 12/16/2024 at 3:43 PM, Resident #12 stated that there used to be 4-5 Certified Nursing Assistants on the unit and now, most of the time, there are only 3 Certified Nursing Assistants. Resident #12 also stated that the 3 nursing assistants have to take care of the whole unit including giving showers, getting residents ready for appointments, and helping residents out of bed after the morning care ended. Resident #12 further stated that because of the low staffing situation, residents cannot get out of bed on time, and it is impossible to have only 3 Certified Nursing Assistants working on the floor and get the work done properly. During an interview on 12/17/2024 at 4:25 PM, Certified Nursing Assistant #14 stated that sometimes the nurse has to come to help out with some residents when their work permits. On 12/18/2024 at 1:00 PM, Certified Nursing Assistant #3 was interviewed and stated that the floor used to have 5 Certified Nursing Assistants, and the facility has not been able to have 5 Certified Nursing Assistants working on the floor for months. Certified Nursing Assistant #3 also stated that it is very hard to work short with 3 to 4 staff as each nursing assistant gets 12 to 14 residents. Certified Nursing Assistant #3 further stated that even when staff is short, they still have to do everything for the residents. Some of the residents are mad, they want to get up early, some of them have appointment, some of them have therapy and it is impossible to do everything and many residents are not happy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On12/18/2024 at 5:15 PM, the Representative for Resident #182 (NY00361139) was interviewed and stated that the facility needs more aides as all residents do not have the same need. Resident #182's Representative also stated that the aides are exhausted, and residents are not getting their needs met. Resident #182's Representative further stated that Resident #182 needs to ambulate on the unit, but the aides do not have the time to ambulate Resident #182 because they are always short of staff. On 12/19/2024 at 11:41 AM, Certified Nursing Assistant #13 was interviewed and stated that not too long ago, in the morning shift on a Sunday, with a census of 40 residents, there were only 2 Certified Nursing Assistants on the unit. Certified Nursing Assistant #13 also stated that a night shift Certified Nursing Assistant did stay over until around 12 noon to help out. Certified Nursing Assistant #13 stated they saw their Union Representative to complain about feeling ill and not being compensated for their missing lunch break on that day. On 12/17/2024 at 1:02 PM, during an interview Registered Nurse #3 stated that an increase in staffing in the part of the Certified Nursing Assistants would be appreciated. Intake for NY00361002 was dated 11/19/2024 and stated that there were staffing issues on the night shift. Intake for NY00340617 was dated 07/15/2024 and stated that there was not enough staff as staff had left employment at the facility and had not been replaced. 33315 On 12/12/24 at 12:53 PM, an interview was conducted with Resident #79 (NY00353498) who stated that the facility is understaffed especially in the evening and mostly on weekends. Resident #79 also stated that sometimes they had not been toileted, and sometimes have to wait until the next day to get showers because there is no one to assist them. Resident #79 further stated that often no one is available to help them get toiletries or what they need to shower, and this has been an ongoing problem and they have complained to the Administrator and the nursing office, but nothing has been done about it. 4. On 12/13/24 at 11:55 AM, an interview was conducted with Resident #92 who stated that staffing is a big concern to them because often times they activate the call bell, and no one shows up. Resident #92 further stated that they could not recall the specific date but recalled that it was on a weekend that they activated the call bell around 11AM and a Certified Nursing Assistant did not assist them until 2 PM. On 12/17/24 at 12:07 PM, an interview was conducted with Certified Nursing Assistant #3 who stated there were times when there were only 2 or 3 Certified Nursing Assistants working on the unit, instead of 4 as scheduled. Certified Nursing Assistant #3 also stated they try to manage but there will definitely be a delay in caring for residents when there are not enough aides. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/17/24 at 09:54 AM, an interview was conducted with Ombudsman who stated they have attended Resident Council meetings several times and the Administrator has also attended at times. The Ombudsman also stated that the majority of residents who attended the meeting complained about low staff that is affecting care especially on the 11 PM to 7 AM shifts and on weekends. Ombudsman further stated that residents informed them that the facility is currently undergoing some transition in ownership which they think is affecting the care they receive. 45351 On 12/19/2024 at 09:59 AM, Certified Nursing Assistant #9 stated they work short especially on the weekends. Certified Nursing Assistant #9 also stated that usually they have two showers to be given on their daily task and are assigned multiple residents requiring two staff or more for their care, so showers are not always feasible when they are working short. On 12/19/2024 at 10:29 AM, Certified Nursing Assistant #10 stated that there are 4 nursing assistants scheduled the day shift and it appears that there is difficulty in covering the missing shift when staff calls out especially the weekends. Certified Nursing Assistant #10 also stated that they are short staffed almost every weekend due to the facility not being able to find coverage to replace staff. On 12/18/2024 at 05:11 PM, the Staffing Coordinator was interviewed and stated that the facility is in contract with three to four nursing agencies, that provide them with Registered Nurses, Licensed Practical Nurses, Certified Nursing Aides, and escorts as needed. The Staffing Coordinator also stated that they have a roster of per-diem staff and part time staff, and they also use overtime with their regular staff. The Staffing Coordinator further stated that a request is submitted to the agencies two weeks, the per diem provides the facility with their availability and the regular staff would call the Nursing office to have their names listed and are available. The Staffing Coordinator stated that vacations are also covered, however, when staff call out or cancel they do their best to find replacement and most of the time we are able to do so. In addition, on weekends or holidays, the Registered Nursing Supervisors are provided the list of names of staff available that they can call in. During an interview on 12/19/2024 at 12:33 PM, the Administrator stated that the current staffing level is sufficient, and staff are scheduled in accordance with the par level. The Administrator also stated that they have been assigning extra nursing staff when allowed to cover any call outs. The facility has sufficient staff to meet the daily par level but there are incidents of staff calling out and they are not able to find replacement staff. The Administrator further stated that the facility has been offering overtime pay for extra shifts and ensure that there are additional staff to call in cases where there are callouts during the weekends. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, interview, and record review conducted during the Recertification and Complaint survey (NY00325467) from 12/12/2024 to 12/19/2024, the facility did not ensure that resident menus and dietary preferences were followed. This was evident for 1 (Resident #103) of 8 residents reviewed for Food out of 38 total sampled residents. Specifically, portion sizes were not consistently followed, and were not provided to Resident #130. The findings are: The facility's policy and procedure titled Resident Food Services revised 1/2024 documented residents will be offered menu choices for all meals, beverages, snacks and are based on their prescribed diet, food preferences, and choices accommodating their allergies, intolerances, preferences and consistent with their plan of care. Resident #103 was admitted to the facility with Diabetes Mellitus, Hyperlipidemia, and Hypertension. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #103 had intact cognition and was independent with eating. During an interview on 12/13/2024 at 2:15 PM, Resident #103 stated they are often served small portion and missing protein on their meal tray. The Comprehensive Care Plan for Nutrition dated 7/16/2024 reviewed 12/12/2024 documented interventions which included to monitor weight, labs, provide diet per physician order, and evaluate needs, eating habits, and preferences. The Dietary note dated 7/23/2024 documented Resident #103 complained they did not receive a protein at lunch yesterday. The Dietary note dated 8/12/2024 documented Resident #103 informed the Registered Dietitian that they were to receive double portion at meals and that their trays are sometimes inconsistent. Resident #103 was upset that their lunch tray today did not have a protein. Registered Dietitian told the resident that this meal ticket reflects no main entree item most likely because of the dislikes regarding an item served for lunch. Resident #103 reported that they will order food in because of these occurrences. During an observation on 12/17/2024 at 1:07 PM, Resident #103's lunch meal ticket documented 1 serving size for all items: 1 salad greens, 1 cranberry juice, 1 peanut butter cookie, 1 apple juice, 1 bowl of chicken noodle soup, 1 portion of eggplant parmesan, 1 portion of corn, red pepper, and green beans, 1 portion of penne pasta. The lunch meal ticket also documented to provide Double Protein as per dietary preference. Resident's plate was observed with 1 slice of eggplant parmesan along with 1 serving size of penne pasta, and corn, red pepper, green beans. There was no double protein observed on Resident #103's tray for the meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/2024 at 11:28 AM, the Clinical Nutritional Director was interviewed and stated there has been ongoing communication with Resident #103 because of a history of not complying with their therapeutic diet. Resident #103 provided their preference for double protein on specific menu items; therefore, it should be reflected on the serving size. The Clinical Nutritional Director also stated they were not able to locate resident's menu preferences in their medical record or meal care system and did not know if double protein was reflected in the serving size and served to Resident #103. The Clinical Nutritional Director further stated that the meal care system prints out resident meal tickets with resident's dislikes/allergies and replaced with other items, however, review of the tickets did not reflect that items were replaced. On 12/18/2024 at 11:09 AM, the Food Service Director was interviewed and stated that Resident #103's lunch menu documented double protein as a dietary preference, but this was not reflected in the serving size of eggplant parmesan served on 12/17/2024. The Food Service Director also stated that the nurse would just call for the double protein when Resident #103's meal tray is being assembled during meal service. The Food Service Director further stated that this has been the practice and so double protein is not reflected in the serving size specification for Resident #103. On 12/19/2024 2:03 PM, the Director of Nursing stated that the Food Service Director has been conducting audits without any issues since they have implemented the new dining process. The Director of Nursing further stated that they were not aware that there were issues related to resident's meals. 10 NYCRR 415.14(c)(1-3)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, interview, and record review conducted during the Recertification and Complaint survey (NY00325467) from 12/12/2024 to 12/19/2024, the facility did not ensure that food was served at an appetizing temperature during meal service. This was evident for 1 (Resident #103) of 8 residents reviewed for Food out of 38 total sampled residents. Specifically, food served during lunch meal service was not maintained at palatable and appetizing temperatures. The findings are: The facility's policy and procedure titled Food Distribution and Service to Residents revised 11/20/2024 stated that each resident would be provided with a nourishing, palatable, diet at proper temperature that meets the dietary needs of each resident. Resident #103 was admitted to the facility with Diabetes Mellitus, Hyperlipidemia, and Hypertension. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #103 had intact cognition and was independent with eating. On 12/13/2024 at 2:15 PM, Resident #103 stated that staff does not serve food immediately on the floor, so food is consistently served cold. Resident #103 also stated that they were told that there is no microwave on the unit and that staff is not allowed to heat up foods due to a safety issue. On 12/16/2024 from 12:35 PM to 12:50 PM, the food cart arrived in the dining room and dietary staff prepared for the meal service on Unit 2 South. On 12/16/2024 from 12:50 PM to 1:29 PM, dietary and nursing staff assembled the trays and distributed the trays to residents in the dining room and delivered to residents in their room. On 12/16/2024 at 1:29 PM, test trays were conducted on Unit 2 South. The food temperatures were mashed potato 145.8 degrees Fahrenheit, diced carrots 114 degrees Fahrenheit, baked chicken leg 140 degrees Fahrenheit, cream of wheat 153 degrees Fahrenheit, ground chicken 117 degrees Fahrenheit, ground green bean 128 degrees Fahrenheit, coffee 116 degrees Fahrenheit and coffee 116 degrees Fahrenheit. On 12/18/2024 at 11:09 AM, the Food Service Director was interviewed and stated that the food temperatures measured on 12/16/2024 were inconsistent and below the optimal temperature for hot foods. The Food Service Director also stated that hot foods are held at least a desirable temperature of 135 degrees Fahrenheit to ensure foods are served hot when residents receive their meal. The Food Service Director further stated that they are always checking temperatures and quality of meals during observations on the units during meal service. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/2024 at 12:33 PM, the Administrator was interviewed and stated that the meal delivery process was changed earlier this year to ensure residents are provided communal dining service. Residents are gathered and served meals in the dining room. The Administrator also stated that the Food Service Director has been monitoring/checking temperatures and food quality on the units during meal service. The Administrator further stated they have not heard of any issues before now and that there is a microwave in the staff dining cafeteria that can be used for heating up foods if needed. 10 NYCRR 415.14(d)(1)(2)