STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335734	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friedwald Center for Rehab and Nursing, L L C	475 New Hempstead Road New City, NY 10956

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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 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect a residents' right to refuse some types of non-requested transfers within the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, conducted during the recertification survey from 7/9/2024 to 7/16/2024, the facility did not ensure a resident's right to refuse a room transfer solely for the convenience of staff. This was evident for 1 (Resident #132) of 37 total sampled residents. Specifically, Resident #132 was transferred from the 2nd Floor to the 3rd Floor after a staff member reported they were uncomfortable providing the resident care. The findings are: The undated facility policy titled Change of Room or Roommate documented the facility reserves the right to make resident room changes when found the facility deems it necessary. A resident has the right to refuse a transfer to another room. Resident #132 had diagnoses of a right femur fracture and end stage renal disease. The Minimum Data Set 3.0 dated 6/6/2024 documented Resident #132 was cognitively intact. During an interview on 07/10/2024 at 12:11 PM, Resident #132 stated that Certified Nursing Assistant #28 reported to the former Director of Nursing and the current Director of Social Work that Resident #132 displayed inappropriate behavior during care. Resident #132 stated they were moved from a room they were comfortable in on the 2nd Floor to the 3rd Floor in 3/2024 to make the Certified Nursing Assistant feel better. Resident #132 denied any inappropriate interaction took place and stated their room was changed after they requested the Certified Nursing Assistant be removed from their assignment. Resident #132 did not recall being interviewed by staff regarding accusations they were inappropriate with the Certified Nursing Assistant. Resident #132 did not feel compatible with the resident population on the 3rd Floor and spent most of their time on the 2nd Floor dayroom to engage with more cognitively intact residents and more stimulating activities. Resident #132 stated facility staff did not follow up after the room change to determine whether they had adjusted to the room and floor change. The Comprehensive Care Plan related to adjustment dated 2/1/2024 documented Resident #132 was at risk for adjustment issues related to their recent hospitalization and admission to the facility. Interventions included honoring Resident #132's preferences and routines. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to being newly admitted to the facility dated 2/1/2024 documented Resident #132 would be introduced to their roommate and co-residents on the unit, oriented to their new environment, and a relationship with Resident #132 should be developed. There was no documented evidence the Comprehensive Care Plans related to adjustment and new facility admission were reviewed and revised to address Resident #132's risk for adjustment difficulties. A Psychiatry Consult dated 3/28/2024 documented nursing staff reported Resident #132 was inappropriate during care and encouraged to ask for privacy if needed. Resident #132 reported the Certified Nursing Assistants became upset when Resident #132 washed certain parts of their body while staff assisted with their bathing routine. It was a delicate issue. The Room Change assessment dated [DATE] documented Resident #132 was moved from the 2nd Floor to a more appropriate bed on the 3rd Floor. Resident #132 was made aware of the room change. The Nursing Note dated 3/29/2024 documented Resident #132 was transferred to the 3rd Floor with all their belongings as per Social Worker #4. The Nursing Note dated 3/30/2024 documented Resident #132 was adjusting well 1 day post room and unit transfer. There was no documented evidence Resident #132 was provided with an opportunity to refuse a room transfer from the 2nd to 3rd Floor based on a staff member's discomfort with providing the resident with bathing assistance. During an interview on 07/16/2024 at 11:28 AM, Social Worker #4 stated they were Resident #132's social worker prior to the move from the 2nd to 3rd Floor. In 3/2024, Certified Nursing Assistant #28 the resident was sexually inappropriate while they provided them with bathing assistance. Resident #132 was cognitively intact, had no psychiatric diagnosis, and had no history of sexually inappropriate behavior during care. Certified Nursing Assistant #28 reported the incident to the former Director of Nursing and the Director of Social Work. Social Worker #4, the Director of Social Work, the Director of Nursing, Resident #132, and the resident's family member made a collective decision to move Resident #132 from the 2nd Floor to the 3rd Floor to separate them from the Certified Nursing Assistant #28. Social Worker #4 stated they did not counsel Resident #132 regarding their alleged sexually inappropriate behavior or document the incident in the resident's medical record. Social Worker #4 said that they should have documented and counseled the resident. Social Worker #4 did not recall whether Resident #132 was introduced to the 3rd Floor and their prospective roommate prior to having their room changed. Social Worker #4 stated the Room Change Assessment should have been more detailed regarding the reason for Resident #132's room change. There was no documentation that Resident #132 agreed with the room change. The social workers did not develop care plans with interventions to address room change adjustment risk. The nursing staff and social workers collectively checked in with residents following room changes to ensure the residents were adjusting well but did not document this in the medical record. (continued on next page)

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F 0560 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/2024 at 11:42 AM, Social Worker #3 stated they were assigned to Resident #132 after the resident moved to the 3rd Floor. Resident #132 was involved in an incident with their assigned Certified Nursing Assistant on the 2nd Floor. The interdisciplinary team addressed the incident by moving Resident #132. Since their move to the 3rd Floor, Resident #132 has interacted well with staff and did not display sexually inappropriate behavior. Resident #132 was also moved to the 3rd Floor because their discharge planning was delayed due to a pending Medicaid application and the 2nd Floor was intended for shorter-term residents. Social Worker #3 stated they checked in on Resident #132 following their room change but did not document the interaction in the medical record and did not develop a care plan with interventions to address potential room change adjustment issues. During interviews on 07/15/2024 at 04:59 PM and 07/16/2024 at 02:30 PM, the Director of Social Work stated social workers were responsible for discussing and obtaining a resident consent for room changes. The Room Change Assessment should detail the reason was moved. But social workers did not document whether the resident agreed to change rooms. The Director of Social Work stated the former Director of Nursing was informed after Certified Nursing Assistant #28 reported that the resident displayed sexually inappropriate behavior during care. The interdisciplinary team met and decided to move Resident #132 off the unit to address Certified Nursing Assistant #28 discomfort. The Director of Social Work did not interview Resident #132 or obtain their statement. The incident was not documented in the resident's medical record and was not investigated by the facility. 10 NYCRR 415.3(d)(2)(ii)(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 40686 Based on observation, interview, and record review conducted during the recertification survey from 7/9/2024 to 7/16/2024, the facility did not ensure the resident's right to a clean, comfortable, and homelike environment. This was evident for 1 (3rd Floor) of 3 resident units. Specifically, the 3rd Floor ad peeling wallpaper in the hallway and a dayroom with walls that were stained and damaged, missing and mismatched wallpaper, and with misshapen and bent window blinds. The findings are: The undated facility policy titled Cleaning and Disinfection documented routine cleaning will be performed in resident common areas and wall cleaning will be conducted when visibly soiled. On 07/09/2024 at 09:39 AM, the 3rd Floor dayroom was observed with window blinds containing several misshapen and bent slates, a quarter-sized hole in the wall next to the television that was crumbling and exposing white dusty plaster beneath, several areas along the wall with remnants of thick white tape, a missing section of wallpaper near the television, and dried food splatters and black scuff along the perimeter of the room on the bottom half of the wall. The hallway to the left of the elevator door had approximately 6 inches of wallpaper near the ceiling that had peeled away from and was hanging off the wall. On 07/16/2024 at 10:45 AM, Housekeeper #20 was interviewed and stated they were responsible for daily dayroom cleaning that included wiping down the walls with cleaning solution. After observing the stains and splatters on the wall, Housekeeper #20 stated they miss cleaning some spots along the wall because the tables, chairs, and residents are sometimes in the way. Resident wheelchairs caused the black scuff marks along the walls, and they were not easily removed by using a cleaning solution. On 07/16/2024 at 10:29 AM, the Director of Maintenance was interviewed and stated renovations of the resident units were ongoing. The 1st and 2nd Floors have already been completed. The facility planned to start renovating the 2nd Floor within the next few months. Soap and water were used to clean the stains and splattered food off the walls in the dayroom. The staff verbally reported to the Director of Maintenance when there were repair needs on the units. The damage to the walls and wallpaper were not repaired because the impending renovation would ensure all those issues were addressed. 10 NYCRR 415.5(h)(2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observation, record review, and interview conducted during a recertification and abbreviated (NY00335338 and NY00341688) survey from 7/9/2024 to 7/16/2024, the facility did not ensure prompt efforts were made to resolve resident grievances for 2 of 2 residents reviewed for grievances (Resident #321 and #136). Specifically, 1) a grievance investigation was not conducted when the Designated Representatives for Resident #321 and Resident #136 expressed care concerns to facility staff. The findings are: The undated facility policy titled Grievances documented when a grievance is reported, the grievance officer and assigned social worker will be notified and an investigation will be conducted. All investigative findings will be discussed with the complainant in writing by the facility within 5 business days, 1) Resident #321 had diagnoses of Parkinson's disease and adult failure to thrive. The Minimum Data Set 3.0 assessment tool dated 4/5/2024 documented Resident #321 had moderately impaired cognition. On 7/15/2024 at 11:00 AM, Resident #321's Designated Representative was interviewed and stated they sent written correspondence to the former Administrator and former Director of Nursing in 1/2024 and 2/2024 regarding several concerns related to Resident #321's care. The Designated Representative did not receive a response from the facility and was not aware whether the facility conducted a grievance investigation to address their concerns. Email communication dated 1/16/2024 documented Resident #321's Designated Representative sent an email to the former Administrator and former Director of Nursing expressing concerns that Resident #321 did not have their clothing changed daily and that resident clothing items did not always come back from laundry. A letter from Resident #321's Designated Representative to the former Administrator and the former Director of Nursing dated 2/15/2024 documented the Designated Representative's had concerns related to staff that was assigned to Resident #321 refusing to take the resident out of bed. There was no documented evidence a grievance investigation was conducted to address clothing and care concerns communicated by Resident #321's Designated Representative to the facility staff on 1/16/2024 and 2/15/2024. On 7/15/2024 at 12:13 PM, Social Worker #3 was interviewed and stated Resident #321's Designated Representative visited daily and expressed care concerns. Social Worker #3 communicated the concerns to nursing staff and did not initiate or conduct any grievance investigations. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/2024 at 2:30 PM, Licensed Practical Nurse #6 was interviewed and stated Resident #321's Designated Representative expressed concerns related to staffing. Licensed Practical Nurse #6 was unaware of any grievance investigations conducted related to these concerns. 40686 2) Resident #136 had diagnoses of dementia and metabolic encephalopathy. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #136 was severely cognitively impaired. On 07/09/2024 at 02:52 PM and 7/10/2024 at 1:07 PM, Resident #136's Designated Representative was interviewed and stated they reported concerns related to care and supervision of Resident #136 to nursing staff on the unit, the Director of Social Work, and Social Worker #3 on several different occasions. A grievance investigation to address their concerns was not conducted. A Social Work Note dated 10/10/2023 documented Resident #136's Designated Representative expressed concerns regarding changes in Resident #136's condition and care team. Emotional support was provided by the Director of Social Work. A Nursing Note dated 5/13/2024 documented Resident #136's Designated Representative requested staff change Resident #136 because the resident's clothing was wet from lunch when liquid spilled on them. Staff attempted to change the resident and the Designated Representative expressed concern related to reddened areas on the resident's skin and fingers. A Follow-Up Meeting Note dated 5/24/2024 documented Resident #136's Designated Representative, the Ombudsman, and facility staff met to discuss concerns related to Resident #136's bruised ear. The Director of Social Work documented that emotional support was provided to the Designated Representative regarding their preferences and for care and recreational activities. There was no documented evidence a grievance investigation was conducted to address care concerns expressed by Resident #136's Designated Representative. On 07/10/2024 at 11:25 AM, the Ombudsman was interviewed and stated a meeting was held with the Administrator, Director of Nursing, Director of Social Work, Social Worker #3, and Resident #136's Designated Representative on 5/17/2024 and no grievance investigation was conducted to address the care concerns expressed by Resident #136's Designated Representative. On 07/16/2024 at 11:48 AM, Social Worker #3 was interviewed and stated Resident #136's Designated Representative visited daily and expressed concerns regarding Certified Nursing Assistants and care provided to the resident. No grievance investigation was conducted to address the Designated Representative's concerns. Social Worker #3 attempted to address the concerns in real time by verbally discussing them with the nursing staff on the unit. A grievance investigation should have been conducted to address the care concerns expressed by the Designated Representative. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 02:36 PM, the Director of Social Work was interviewed and stated any resident or family had the right to request a grievance and receive a verbal report of the outcome of the investigation within 5 days. There were Grievance Log binders on each unit and grievances forms were accessible for investigations to be initiated at any time and with any staff member. On 07/16/2024 at 03:23 PM, the Administrator was interviewed and stated they were present at a meeting with Resident #136's Designated Representative to discuss concerns related to a an ecchymotic area on Resident #136's ear. The Administrator did not know whether Resident #136's Designated Representative was offered the opportunity to file a grievance. The Administrator stated they did not have access to the former Administrator's emails and correspondence prior to today. The Administrator stated that email correspondence from Resident #321's Designated Representative was received and in the email inbox. A grievance investigation should have been conducted to address the concerns expressed by Resident #321's Designated Representative. 10 NYCRR 415.3(d)(1)(ii)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00314688) survey from 7/9/2024 to 7/16/2024, the facility did not ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, to the New York State Department of Health. This was evident for Resident #136 reviewed for abuse out of 37 total sampled residents. Specifically, an allegation of abuse related to ecchymosis (bruising) found on Resident #136's ear was not reported to the New York State Department of Health. The findings are: The facility policy titled Abuse, Neglect, and Exploitation dated 10/1/2023 documented allegations involving abuse will be reported immediately, but not later than 2 hours after the allegation is made, to the Administrator and state agency. Resident #136 had diagnoses of dementia and metabolic encephalopathy. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #136 had severe cognitive impairment. On 07/09/2024 at 02:52 PM and 7/10/2024 at 1:07 PM, an interview was conducted with Resident #136's Designated Representative who stated Resident #136 had an ecchymotic area on their outer left ear found by nursing staff on 4/27/2024. The area was red and swollen. The facility nursing staff explained that the redness was from anticoagulant therapy. Resident #136's Designated Representative had the resident evaluated by the Dermatologist on 5/1/2024. The Dermatologist determined Resident #136 had trauma to their ear and contacted Adult Protective Service to support a suspicion of abuse. A meeting was held with the facility staff and Ombudsman because the Designated Representative was not satisfied with the facility's explanation of Resident #136's ear ecchymosis. The Administrator stated they would not report the alleged traumatic physical injury to the New York State Department of Health. The Accident/Incident Investigation Form dated 4/27/2024 documented Resident #136 was found with a discoloration to their outer ear at 11:45 PM. A dermatology Consult dated 5/1/2024 was included in the facility's investigation. The Investigation Form was signed on 4/28/2024 and recommended a Psychiatry Consult. Dermatology Consult dated 5/1/2024 documented Resident #136 was evaluated for ecchymotic area to their left outer ear. Trauma was suspected and the Dermatologist contacted the Adult Protective Services to report alleged abuse. The Investigation Form dated 5/10/2024 documented Resident #136's Designated Representative alleged physical trauma was the cause of Resident #136's left ear discoloration. The investigation revealed no evidence to support abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the facility reported Resident #136's left outer ear ecchymosis to the New York State Department of Health upon allegations of abuse by the Designated Representative and Dermatologist. On 07/16/2024 on 03:23 PM, the Administrator was interviewed and stated that the former Director of Nursing was responsible for the investigation into Resident #136's left ear discoloration. An investigation to rule out abuse was conducted. No abuse occurred. By the time the Administrator learned of the occurrence, it was past the 2 hour timeframe to report to the New York State Department of Health and the Administrator decided not to make a report. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observations, interview, and record review conducted during the recertification and abbreviated (NY00314688) survey from 7/9/2024 to 7/16/2024, the facility did not ensure all alleged violations involving abuse were thoroughly investigated. This was evident for Resident #136 reviewed for abuse out of 37 total sampled residents. Specifically, an allegation of abuse related to ecchymosis found on Resident #136's ear was not thoroughly investigated to include interviews with the Dermatologist who assessed and determined Resident #136 experienced physical trauma. The findings are: The facility policy titled Abuse, Neglect, and Exploitation dated 10/1/2023 documented allegations involving abuse will be reported immediately, but not later than 2 hours after the allegation is made, to the Administrator and state agency. Resident #136 had diagnoses of dementia and metabolic encephalopathy. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #136 was severely cognitively impaired. On 07/09/2024 at 02:52 PM and 7/10/2024 at 1:07 PM, an interview was conducted with Resident #136's Designated Representative who stated Resident #136 had an ecchymotic area on their outer left ear found by nursing staff on 4/27/2024. The area was red and swollen. The facility nursing staff explained that the redness was from anticoagulant therapy. Resident #136's Designated Representative had the resident evaluated by the Dermatologist on 5/1/2024. The Dermatologist determined Resident #136 had trauma to their ear and contacted Adult Protective Service to support a suspicion of abuse. A meeting was held the facility staff and Ombudsman because the Designated Representative was not satisfied with the facility's explanation of Resident #136's ear ecchymosis. The Accident/Incident Investigation Form dated 4/27/2024 documented Resident #136 was found with a discoloration to their outer ear at 11:45 PM. A dermatology Consult dated 5/1/2024 was included in the facility's investigation. The Investigation Form was signed on 4/28/2024 and recommended a Psychiatry Consult. Dermatology Consult dated 5/1/2024 documented Resident #136 was evaluated for ecchymotic area to their left outer ear. Trauma was suspected and the Dermatologist contacted the Adult Protective Services to report alleged abuse. The Investigation Form dated 5/10/2024 documented Resident #136's Designated Representative alleged physical trauma was the cause of Resident #136's left ear discoloration. The investigation revealed no evidence to support abuse. There was no documented evidence the facility conducted a thorough investigation into reported Resident #136's left outer ear ecchymosis to include interviews with the consulting Dermatologist related to their assessment of trauma to the Resident's ear and report to Adult Protective Services. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 on 03:23 PM, the Administrator was interviewed and stated that the former Director of Nursing was responsible for the investigation into Resident #136's left ear discoloration. An investigation to rule out abuse was conducted. No abuse occurred. The Administrator was unsure if the Dermatologist was contacted by the former Director of Nursing as part of their investigation and believed that a thorough investigation was completed. 10 NYCRR 415.4(b)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41666 Based on observations, interviews and record review conducted during a recertification survey and abbreviated survey (NY00322156) conducted from 7/08/24-7/16/24 , the facility did not ensure that a comprehensive person-centered care plan was developed for 1 of 1 residents (#127) reviewed for urinary tract infections. Specifically, there were no care plans in place to address prevention of reoccurring urinary tract infections for Resident #127. Findings include: The undated facility policy titled Comprehensive Care Plans documented the facility was to develop and implement a comprehensive person-centered care plan for each resident with resident rights, that included measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs. Resident #127 was admitted with diagnoses and conditions including Dementia, Diabetes Mellitus, and history of Urinary Tract Infections. The Minimum Data Set an assessment tool dated 4/11/24 documented Resident #127 had severe cognitive impairment and was dependent on staff for all activities of daily living and was incontinent of bladder and bowel. The 5/2/24 Physician Note documented the resident presented with increased confusion. Urine analysis and culture ordered. The 5/4/24 Nursing Note documented the resident was started on Cipro 250 mg for cystitis. The 6/28/24 Nursing Note documented start on pipercillin intravenous for cystitis. The 7/2/24 Nursing Note documented intravenous antibiotics in progress, incontinent care rendered. There was no documented evidence in the electronic medical record indicating a comprehensive care plan to address urinary tract infection/s had been developed. During an interview 07/12/24 at 10:29 AM Registered Nurse #12 stated the resident was at risk for urinary tract infection/s because they were immobile, incontinent, had dementia and was dependent on staff for all cares. Registered Nurse #12 stated it was their responsibility to initiate a care plan to address concerns including antibiotic use and monitoring but, it had not been done yet. 10NYCRR 415.11(c)(1)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friedwald Center for Rehab and Nursing, L L C	475 New Hempstead Road New City, NY 10956

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 40686 Based on observation, interview, and record review conducted during the recertification survey from 7/9/2024 to 7/16/2024, the facility did not ensure a resident received treatment and services in accordance with professional standards of practice and their comprehensive person-centered care plan. This was evident for 1 (Resident #65) of 37 total sampled residents. Specifically, Resident #65 was observed out of bed in a reclining back wheelchair seated on a hoyer pad and there was no documented evidence to address the level of assistance and devices required for safe bed-to-chair transfer. The findings are: Resident #65 had diagnoses of cerebral infarction and left side hemiplegia. The Minimum Data Set (assessment tool) dated 6/20/2024 documented Resident #65 had severe cognitive impairment, was dependent on staff assistance for bed-to-transfers and did not use a wheelchair or mobility device. On 07/10/2024 at 01:49 PM, 07/12/2024 at 10:20 AM, and 07/15/2024 at 12:54 PM, Resident #65 was observed out of bed in a reclining back wheelchair with a hoyer lift canvas underneath them. There was no documented evidence in the Care Plan related to activities of daily living initiated 2/1/2024 and last reviewed 6/21/2024 to address the level of assistance and devices required for safe bed-to-chair transfer. There was no documented evidence in the Occupational Therapy Discharge Note dated 4/18/2024 to address the level of assistance and devices required for safe bed-to-chair transfer. The July 2024 Certified Nursing Assistant Documentation Survey Report documented Resident #65 was totally dependent on 2 people for transfers on 12 occasions, totally dependent on 1 person for transfers on 4 occasions and required the extensive assistance of 1 person on 1 occasion. There was no documented evidence in the Certified Nursing Assistant Kardex Instruction Sheet as of 7/15/2024 to address the level of assistance and devices required for safe bed-to-chair transfer. On 07/15/2024 at 04:13 PM, Certified Nursing Assistant #23 stated they were unable to access Resident #65's instructions on the computer console. They did not know what was documented for Resident #65's transfer status and relied on verbal instruction from their coworkers. On 07/16/2024 at 01:33 PM, Certified Nursing Assistant #22 stated they were unable to access the electronic medical record on the computer console and did not know what instructions were listed for how to transfer Resident #65 from bed to wheelchair. They asked the nurse how to transfer Resident #65 out of bed and was told to use a Hoyer lift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/16/2024 at 01:43 PM, Registered Nurse #12 was interviewed and stated a resident's transfer status was included in the care plan and then populated the Certified Nursing Assistant instruction sheet. A physician order should be obtained for resident requiring hoyer lift transfers. The nurse manager was responsible for checking to ensure transfer orders were in place. The rehabilitation department was responsible for checking quarterly during scheduled assessments of the residents. Resident #65 required a hoyer lift for transferring out of bed to the wheelchair. Registered Nurse #12 checked the medical record and stated there were no transfer orders documented for Resident #65. On 07/16/2024 at 12:14 PM, the Director of Rehabilitation stated they had been working at the facility for 3 months. The rehabilitation department screens residents and recommends devices for positioning and transfers. These recommendations were communicated to the nursing department either verbally or through a progress note written by the occupational therapist in the electronic medical record. The occupational therapist initiated a physician order for hoyer lift transfers and the nursing department was responsible for getting the order signed. The certified nursing Instructions were automatically pre-populated with hoyer lift instructions once a physician order was obtained. The Director of Rehabilitation confirmed there were no transfer orders for Resident #65 and there were no instructions on the resident's chart that indicated hoyer lift transfers were required. 10 NYCRR 415.12

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47626 Based on observations, interviews, and record review during a recertification survey conducted from 7/9/24-7/16/24, the facility did not ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 2 of 8 residents (Resident #21 and #98) reviewed for positioning and mobility. Specifically, the staff did not ensure 1) Resident # 21's bilateral hand splints were worn throughout the day as ordered and care planned and 2) Resident #98's right-hand splint was worn as per physician order. The finding is: A Policy and Procedure dated 2/21 titled Rehabilitation Positioning Devices, documented ensure residents were proper position and body alignment with appropriate positioning devices as needed. 1) Resident #21 was admitted with diagnosis of Multiple Sclerosis, Functional Quadriplegia and Type 2 Diabetes. The Quarterly Minimum Data Set (an assessment tool) dated 4/18/2024 documented Resident #21 was cognitively intact and was dependent with all activities of daily living. The 3/20/2024 care plan titled Rehabilitation Positioning Device documented bilateral hand splints throughout the day for prevention of further contracture. Perform hygiene care and skin checks to ensure no skin breakdown/discomfort pre and post use. The 3/20/24 physician order documented bilateral hand splints throughout the day for prevention of further contracture. There was no documented evidence in the electronic medical record prior to 7/12/24 to indicate the hand splints were applied. During an observation on 07/09/24 at 10:43 AM Resident # 21 was in bed, both hands were contracted. Hand splints were not in place as per physician order and were noted on the bedside table. During an observation on 07/10/24 at 8:45 AM Resident #21 was in bed. Hand splints were not in place as per physician order. During an observation on 07/10/24 at 12:13 PM and 2:10 PM Resident #21 was out of bed in the wheelchair. Hand splints were not in place as per physician order. During interview on 7/12/24 at 8:29 AM Certified Nurse Aide #7 stated they usually applied splints on both hands after AM care/s. Certified Nurse Aide # 7 stated they were aware the resident should wear the splints on their hands throughout the day and the splints should be removed after PM care/s. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/12/24 at 8:31 AM Licensed Practical Nurse #6 stated they put the splints on the resident after AM care. Licensed Practical Nurse # 6 stated the physician order referencing throughout the day indicated the splints should be applied after AM care and should be worn until PM care. During interview on 7/12/24 at 9:15 AM the Director of Nursing stated the certified nurse aides should put the resident's splints on and the nurses were responsible for checking to ensure the splints were in place and should sign off in the treatment administration record. The Director of Nursing stated when the physician order was put in place the order did not carry over to the treatment administration record, therefore the nurses were not able to sign off that they were monitoring the application of the splints. 50816 2) Resident #98 was admitted with diagnosis including right hemiplegia and hemiparesis following cerebral infarction The 4/18/22 Annual Minimum Data Set (an assessment tool) documented Resident # 98 had severe cognitive impairment, functional limitation in range of motion of the upper extremity and was dependent with all activities of daily living. The 3/20/24 physician order documented Resident #98 was to wear a right-hand grip II splint throughout the day for prevention of further contracture. The 3/20/24 care plan titled Positioning Device documented resting hand splint throughout the day for prevention of further contracture. During observation on 7/09/2024 at 12:52 PM, Resident #98 was in bed, their right hand was clenched closed, the hand splint was on the right arm and not on the right hand as per physician order. During observation on 7/10/24 at 8:54 AM and 7/11/24 at 12:08 PM Resident #98 was in bed, their right hand was clenched closed. The right-hand splint was not on the right hand as per physician order. During interview on 7/11/2024 at 12:08 PM, Certified Nursing Assistant #1 stated the resident's right hand splint was not in place. Certified Nursing Assistant #1 stated they were aware that Resident #98 was supposed to wear the right-hand splint, but the resident refused to wear it. Certified Nursing Assistant #1 stated they reported resident refusal to the nurse and the therapist and had been told to put the splint back on. During interview on 7/11/24 at 1:18 PM Registered Nurse/Charge Nurse # 2 stated the certified nurse assistants were responsible for putting the splint on and the nurses were responsible for checking that the splint had been applied. During the interview Registered Nurse/Charge Nurse # 2 stated the resident care plan documented the splint was to be worn throughout the day and indicated it should be on during the 7-3 shift. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/11/2024 at 1:18 PM Registered Nurse/Charge Nurse # 2 stated the nurses were responsible for creating and updating care plans. Registered Nurse/Charge Nurse # 2 stated the care plan did not indicate the resident refused cares or the use of the right-hand splint. Registered Nurse/Charge Nurse # 2 stated a plan should be in place if the resident was removing the right-hand splint. Registered Nurse/Charge Nurse # 2 stated the nurses were responsible for supervising the certified nurse assistants and were responsible for documenting the use of the right-hand splint in the medication or treatment administration record. Upon checking Registered Nurse/Charge Nurse # 2 stated there was not a directive in the administration record for the use of the right-hand splint. Registered Nurse/Charge Nurse # 2 stated the resident should have the splint in place to prevent contracture of the right hand. 10NYCRR 415.12

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49364 Based on staff interview and review of facility records during the recertification survey from 7/9/24 through 7/16/24, the facility did not ensure certified nurse aide performance reviews were completed at least once every 12 months. Specifically, five of seven certified nurse aides did not have performance reviews documented at least once every 12 months. Findings include: Review of Certified Nurse Aide #7, #17, #24, #25, and #26 hire dates revealed they had been working at the facility for more than one year. The review of performance evaluations for Certified Nurse Aide #7 and #17 revealed their last performance evaluations were completed on 8/4/08 and 3/15/10 respectively. There was no documented evidence that performance evaluations were completed for Certified Nurse Aide #24, #25 and #26. During an interview on 07/15/2024 at 11:22 AM, the Human Resources Director stated the annual performance evaluations for the Certified Nurse Aides were not done, the facility was in the process of getting them done with the new administrator on board. During an interview on 7/15/2024 at 12:06 PM, the Director of Nursing stated yearly certified nurse aide performance assessments were once done by the previous Director of Nursing and the facility was currently in the process of bringing back the yearly evaluation assessments for the certified nurse aide and nurses. During an interview on 7/16/2024 at 9:16 AM, Certified Nurse Aide #17 stated they could not recall when they last had a performance evaluation done. During an interview on 7/16/2024 at 9:18 AM, Certified Nurse Aide #18 stated the facility did in-services with the certified nurse aides but not performance evaluations. During an interview on 7/16/2024 at 9:23 AM Certified Nurse Aide #19 stated they did not have a recent performance evaluation done. 10NYCRR 415.26(c)(1)(IV)

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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. 49364 Based on observation, interview, and record review during the recertification survey from 7/9/24 through 7/16/24, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional standards for 2 of 26 residents (Resident #378 and #425) reviewed for medication storage and labeling . Specifically, 1. Nystatin-Triamcinolone cream with a 6/14/24 -6/28/24 administration date was observed on Resident # 378's bedside table and 2. Fluticasone and Albuterol metered dose inhalers were observed on Resident # 425's bedside table. The findings are: The undated policy titled Resident Self-Administration of Medication documented all nurses and nurse aides were required to report any medication found at the residents' bedside to the charge nurse. 1. Resident # 378 was admitted to the facility with diagnoses including Diabetes, Chronic Kidney Disease and Peripheral Vascular Disease. The Minimum Data Set (an assessment tool) dated 5/9/24 documented Resident #378 was cognitively intact. Observation on 07/09/24 at 12:23 PM, 07/09/24 at 03:50 PM, 7/10/24 at 10:06 AM, 7/11/24 at 10:02 AM, and 7/12/24 at 8:43 AM revealed a tube of Nystatin-Triamcinolone cream was on Resident #378's bed side table. During an interview on 7/12/24 at 8:54 AM, Licensed Practical Nurse #27 stated Resident #378 did not currently have a physician order for the application of Nystatin-Triamcinolone cream. During an interview on 7/12/24 at 9:00AM, Licensed Practical Nurse # 13 stated the resident had redness to the perineal area and needed the Nystatin-Triamcinolone cream, but, there was no longer an order for the administration of the cream. Licensed Practical Nurse #13 stated medicated creams should not have been left at the bedside. 2. Resident # 425 was admitted to the facility with diagnoses including Asthma, Hypertension, and Hypothyroidism. The Minimum Data Set (an assessment tool) dated 7/5/2024 documented Resident # 425 was cognitively intact. During observation on 7/9/24 at 12:10 PM, 7/10/24 at 9:10 AM, and 7/12/2024 at 9:28 AM a plastic storage bag containing Fluticasone and Albuterol meter dose inhalers were noted on Resident #425's bedside table. During an interview on 7/12/24 at 9:24 AM, Certified Nurse Aide #27 stated they had seen the resident's inhalers on the bedside table, and did not report it to the nurse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 9:29 AM, Resident #425 stated the inhalers at the bedside were labeled with another facility's name. During an interview on 7/12/24 at 9:36 AM, Licensed Practical Charge Nurse #15 stated they found the medication/s in the resident's room at the bedside. Licensed Practical Nurse #15 stated the inhalers at the resident's bedside were from the hospital and should not have been left at the bedside. Licensed Practical Charge Nurse #15 stated they did not know the resident had their own medication at the bedside. 10 NYCRR 415.18 (d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on observation, record review and interview conducted during a recertification survey conducted from 7/9/24-7/16/24, the facility did not ensure infection control prevention including proper use of personal protective equipment and enhanced barrier precautions were maintained to help prevent the development and transmission of communicable diseases and infections for 2 of 32 residents (#130 and #72). Specifically, 1) contact precautions were not followed when Activity Aide #9 touched an overbed table in Resident #130's room and 2) enhanced barrier precautions were not implemented when Certified Nurse Assistant #10 and Certified Nurse Assistant #11 transferred Resident #72 into bed by Hoyer lift. Findings include: The undated facility policy for enhanced barrier precautions documented precautions were an infection control intervention designed to reduce transmission of multi drug resistant organisms that employed targeted gown and glove use during high contact resident care activities. High contact care activities include transfer from chair to bed. 1) Resident #130 was admitted with diagnoses including Diabetes Mellitus, End Stage Renal Disease, and Clostridium Difficile infection. The Quarterly Minimum Data Set (an assessment tool) dated 5/22/24 documented the resident had intact cognition and was totally dependent on staff for toileting, and transfers. The Physician Order dated 7/5/24 documented contact isolation for clostridium difficile infection and vancomycin 50 mg/cc 5 milliliters by mouth four times a day. During observation on 7/10/24 at 10:15 AM a sign documenting contact precautions: put on gloves and a gown before entering the room was outside Resident #130's room. During a short interview at that time Licensed Practical Nurse #15 was asked why the resident was on contact isolation and stated it was because the resident had a clostridium difficile infection. During observation on 7/10/24 at 10:25 AM Recreation Aide #9 entered Resident #130's room without donning gloves and a gown and was observed touching the residents overbed table. During an interview with Recreation Aide #9 on 7/10/24 at 10:25 AM they stated they usually brought the activity schedule to the resident and arranged the room activities for the resident. Recreation Aide #9 stated they were told by the nursing staff the yellow contact signs meant they did not need a gown when dropping things off and were told to wash their hands with antibacterial hand sanitizer when they exited the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/12/24 at 9:18 AM Licensed Practical Nurse #19 stated clostridium infection was highly transmissible and could stay on surfaces longer. Licensed Practical Nurse # 19 stated the recreation aide had it all wrong and should have looked at the door and ask nursing staff before entering the room. Licensed Practical Nurse # 19 stated staff could not use antibacterial hand sanitizer for clostridium difficile and must wash hands with soap and water. 2) Resident #73 had diagnoses including Alzheimer Disease, Atrial Fibrillation, and Dysphagia. The Quarterly Minimum Data Set (an assessment tool) dated 4/25/24 documented the resident had severe cognitive impairment and was dependent on staff for all care. The resident had an indwelling feeding tube. The Physician Order dated 3/27/24 documented enhanced barrier precautions for gastrostomy tube. During observation on 7/9/24 at 3:23 PM a sign documenting enhanced barrier precautions everyone must wear gloves and gown for the following high contact resident care activities dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, and assist with toileting outside was outside Resident #72's room . During observation 07/09/24 at 3:23 PM Certified Nurse Assistant #10 and Certified Nurse Assistant #11 were observed transferring Resident #72 into their bed from their chair with their clothing coming in contact the rails on the residents bed Both Certified Nurses Assistant #10 and Certified Nurses Assistant#11 were not wearing a gown as indicated on the enhanced barrier precaution signage. During an interview on 7/9/24 at 3:23 PM Certified Nurse Assistant #10 and Certified Nurse Assistant #11 stated they knew to wear gloves when touching the resident but didn't need a gown because that was only during wound dressing changes and not when getting residents back to bed. During an interview on 7/16/24 at 1:35 PM the Infection Preventionist stated they had provided in services regarding enhanced barrier precautions. The infection Preventionist stated they made rounds and corrected certified nurse assistants whenever it was needed. 10 NYCRR 415.19 (b) (4)