STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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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 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** Based on observation and staff interviews during a recertification survey, the facility did not ensure a safe, comfortable home-like environment and effective housekeeping and maintenance services were maintained for 5 (Units A, B, C, D, and G) of 5 resident units. Specifically, for all units, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood; for Unit A, there was not sufficient hot water to the resident's rooms; for Units B, C, D, and G, the bathrooms were not fully cleaned, tidy, and lights in residents bathroom not working. This is evidenced by: The undated Policy &Procedure, titled Maintenance/Housekeeping Work Order Policy, documented that it was the facility's policy to ensure all areas maintained a clean, comfortable, and well-functioning environment. When problems were identified, employees were required to complete a Maintenance/Housekeeping Work Order. Observations: Observations on Unit A were as follows; -On 1/13/2025 at 12:14 PM, room [ROOM NUMBER] lighting in the bathroom was not fully lit only dimly working and the water was not hot and took approximately 3 minutes to get to a comfortable temperature. The door handle on the inside of room [ROOM NUMBER] sticks and unable to open the door. -On 1/13/2025 at 12:59 PM, Handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood. -On 1/13/2025 at 3:32 PM, in room [ROOM NUMBER], the toilet was stained with a reddish color and had not been cleaned Observations on Unit B were as follows; -On 1/13/2025 at 11:49 AM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood. -On 1/13/2025 at 12:22 PM, the resident stated that it was hard to regulate the heat in the room which gets very warm sometimes too warm. (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: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Delmar Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Rockefeller Road Delmar, NY 12054	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on Unit C were as follows: -On 1/13/2025 at 12:41 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood. -On 1/13/2025 at 11:49 AM, multiple shared bathrooms were not cleaned and had buildup around toilets and in corners of bathrooms. Observations on Unit D were as follows; - On 1/13/2025 at 12:07 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood. - On 1/13/2025 at 11:13 AM, Room A-10 was very dirty. The room was cluttered with equipment, a wheelchair, and a walker. The areas around the bathroom door and entry door in the hinged corner crusted with dirt and dust. The floor and bedside tray were sticky with spilled food. - On 1/13/2025 at 4:50 PM, Resident room A-10 still had cluttered equipment in the room as well as uncleaned areas. The resident's floor still had areas that were not cleaned from the previous observation. Observations on Unit G were as follows: - On 1/13/2025 at 10:58 AM, room [ROOM NUMBER] had valance coming off the holder above the window, and exposed radiator tubing under the radiator. - On 1/13/2025 at 11:46 AM, the bathroom for room [ROOM NUMBER] had no light working. - On 1/13/2025 at 12:41 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood. During an interview on 1/14/2025 at 2:21 PM, Family Representative #2 reported there was always a smell on the unit from bags when they change people. They stated staff left the bags in the hallway and then removed them to the soiled linen room at a later time. They stated that housekeeping was less to be desired, and they did not do the proper cleaning of areas as they felt the floors were not properly cleaned. During an interview on 1/21/2025 at 11:04 AM, Director of Housekeeping #1 stated that resident rooms were cleaned daily. They stated they did a 4/10 daily cleaning of the rooms in which they clean the high-touch areas, made sure there was no dust in the rooms, cleaned the bathroom, sweep and mopped the floors. They stated that they did a 10/10 deep clean of the room when a resident was discharged , or a resident changed room. They stated they did evaluations and inspections on rooms occasionally and kept records of what was cleaned. They stated they may have to increase the consistency of spot inspections for their staff. Currently, they stated they did not have any complaints or grievances when it came to the cleanliness of resident rooms. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/23/2025 at 9:45 AM, Director of Maintenance #1 stated the unit damage to the walls, doors, and handrails happened from residents' grabbing and scratching the rails as well as their wheelchairs or stretchers hitting it. If any damage to the walls occurs or other issues the staff need to inform maintenance so they could fix it. Director of Maintenance #1 stated they had not received any work orders related to any issues within the units. Work orders were created by staff when an issue occurred and were placed in a work order book. Maintenance would then review the books several times a day and fix any immediate issues they find. They stated that if a part needs to be ordered then the work order did not get completed. Director of Maintenance #1 stated that they did not notify residents that the order could not be completed due to a part being ordered. They stated that they were aware of the handrails but have not done anything yet to correct them. e Director of Maintenance #1 stated that the building was old. They stated that the facility was working with an outside contractor to replace all of the current lights in the building with higher-efficiency LED lighting. They stated that they had completed the main areas and hallways and were now transitioning to resident rooms which they believed would start very soon. They stated that they were aware that hot water took some time to get from the boiler to the resident's room on the far side of the building. They have instructed staff to let water run to get the hot water circulating through the system to the resident' rooms and showers in those locations. Director of Maintenance #1 stated that they were transitioning heating and air-conditioning units in the resident's rooms to newer units. If an issue regarding the units was reported, then the maintenance department would correct it by replacing the unit in the resident room. In mentioning room [ROOM NUMBER], Director of Maintenance #1 viewed the exposure of the hoses under the radiator system. They stated that the unit was smaller, and they would need to do something regarding the exposed hoses. In mentioning the exposed old radiator piping they stated that they would need to do something about that as well since these were a smaller unit. 10 New York Codes of Rules and Regulations 415.5(h)(2)

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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. Based on observation, record review and interviews during the recertification survey, the facility did not ensure the resident's right to be free from abuse and neglect for 1 (Resident #40) of 40 residents reviewed for abuse and neglect. Specifically for Resident #40, a Certified Nurse Aide did not follow the resident's comprehensive care plan when giving personal care, during which the resident fell from their bed and sustained a broken leg on 10/01/2024. This is evidenced by: A policy titled, Abuse Policy, revised 12/2022, documented that the facility prohibited the mistreatment, neglect, and abuse of residents/patients and misappropriation of the resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The policy further documented that neglect was defined as failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or distress. Under Abuse - Protocol, it was documented that the Administrator and Director of Nursing were responsible for investigating and reporting. Under Abuse - Prevention, it was documented that to identify, correct, and intervene in situations where abuse, neglect, and or mistreatment were more likely to occur included but was not limited to identification/analysis of sufficient staffing on each shift to meet the needs of the residents/patients, assigned staff demonstrating knowledge of individual resident/patient needs, and sufficient and appropriate supervisory staff to identify inappropriate behaviors. Resident #40 was admitted to the facility with the diagnoses of seizure disorder (brain condition that causes episodes of abnormal electrical activity in the brain), morbid obesity (severe form of obesity that's characterized by a high body mass index), and bipolar disorder (mental illness that causes extreme mood swings). The Minimum Data Set (an assessment tool) dated 10/16/2024, documented that the resident was able to understand others, be understood, was minimally cognitively impaired, and needed significant help with activities of daily living. Review of the Comprehensive Care Plan for Activities of Daily Living, created 12/04/2023 and last updated 10/09/2024, documented the goal of Resident's activities of daily living status will improve through the review date. The documented interventions included that Resident #40 was dependent on 2 or more staff members and did not use their own strength to complete the following tasks: Shower/Bathe Roll Left and Right: Dependent x2 or more staff Lying to Sitting on Side of Bed Personal Hygiene Toileting Hygiene (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan for mobility, created 12/01/2023 and updated 10/09/2024, documented the goal that the resident would remain free of complications related to immobility, including contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes limb stiffness and shortening), thrombus formation (a blood clot formed in a blood vessel or the heart), skin-breakdown, and falls with related injury. The documented interventions included but were not limited to, wheeling in wheelchair (resident was dependent on at least one person to physically assist them to complete the task). The resident did not use own strength for any part of the activity. A facility incident report, dated 10/01/2024 at 6:31 PM, documented that Resident #40 had fallen out of bed while being cared for by Certified Nurse Aide #5. Resident #40 stated per the report, documented that the staff member was assisting them to roll over, the resident rolled too close to the edge of the bed and fell off it. Registered Nurse #6 was called to assess Resident #40, and the decision was made to send the resident to the hospital because the resident was complaining of pain to their leg, had struck their head, was on Eliquis (a blood thinner), and they had a laceration on their toe which was bleeding. A hospital orthopedic (a doctor that specialized in bones and tendons) consultation note dated 10/02/2024 at 2:54 AM documented that Resident #40 had sustained a right distal femur fracture (a break in the lower part of the right thigh bone, just above the knee joint). Resident #40 did not require surgical intervention for the fracture. During an interview on 1/13/2025 at 11:58 AM, Resident #40 stated that in October 2024, they were getting cleaned up and Certified Nurse Aide #5 rolled them over too far, and they fell out of bed and broke their leg. Resident #40 stated that Certified Nurse Aide #5 had been fired after the fall. Resident #40 stated that they did not like getting out of bed because it required a Hoyer lift and that they could not stand on their own because of their leg. During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #4 stated that the Director of Nursing kept all incident reports and investigations in their office and reports would need to be requested directly from the Director of Nursing. Additionally, Licensed Practical Nurse #4 stated that documentation of resident incidents and complaints were never documented in Point Click Care (the electronic system used by the facility), only on the incident report sheets completed by Director of Nursing or Administrator, and they were the only authorized staff to report incidents to the Department of Health. During an interview on 1/21/2025 at 2:02 PM, Licensed Practical Nurse #1 stated they were educated on abuse and neglect yearly. If a resident sustained a fall during care, if anything was broken, it would require reporting, and possibly call 911. During an interview on 1/21/2025 at 2:16 PM, Registered Nurse Manager #1 stated that for falls with injuries, the Unit Manager should have been notified immediately. The Director of Nursing should have been notified immediately. Additionally, only the Director of Nursing or the Administrator reported to Department of Health, but if the Registered Nurse Manager #1 thought an incident needed to be reported and thought that no one had reported it, the Registered Nurse Manager #1 would call themselves. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that if the resident fell because of a care plan violation, the Department of Health had to be called within 2 hours. If the staff did not know how the resident got injured, that would also be a reportable incident. The employee involved would be sent home and investigation would begin. If a resident sustained an injury and the source of the injury could be explained, or if there was no violation of the care plan, no reporting would be required. Additionally, Director of Nursing #1 stated that abuse training was provided to all staff annually, when something adverse occurred, or if they felt the staff needed a refresher. Director of Nursing #1 stated that agency staff were educated on the facility's abuse policy during their orientation. During an interview on 1/22/2025 at 1:00 PM, Administrator #1 stated that they would report all allegations of abuse in 2 hours if they were found to be substantiated. Administrator #1 also stated the regulation for reporting abuse stated that all abuse needs to be reported in 2 hours and that they would attempt to unsubstantiate the abuse allegations within two hours. Administrator #1 stated that if there were multiple witnesses to the incident, if a staff member was not working, or if there was no evidence of abuse, they would consider the allegation unsubstantiated and not report it. Administrator #1 stated that the first thing to do would be to suspend the accused staff member and then complete the investigation. They stated if they believed abuse or neglect had occurred, they would report the incident to the Department of Health within 2 hours. 10 New York Code of Rules and Regulations 483.12 (a) (1)

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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. Based on record review and interview during the post-survey revisit and abbreviated survey (Case # NY00376983), the facility did not have evidence that all alleged violations were thoroughly investigated for 1 (Resident #365) of 4 residents reviewed. Specifically, the facility did not have evidence of thorough investigation when Resident #365 reported they injured their hand on the front door when they were coming back into the facility at 11:00 PM on 3/25/2025. This is evidenced by: Cross-reference to F689: Free of Accident Hazards/Supervision/Devices Resident #365 Resident #365 was admitted to the facility with diagnoses of type 2 diabetes mellitus (chronic metabolic disease characterized by persistently high blood sugar levels) without complications, nicotine dependence - cigarettes, and schizophrenia (a serious mental condition that effects how people think, feel, and behave). The Minimum Data Set, dated (an assessment tool) dated 2/27/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The Policy and Procedure titled, Accident – Incidents, revised 7/2020, documented it was the policy of the facility to monitor and evaluate all occurrences of accidents of incidents or adverse events occurring on the facility ' s premises, which was not consistent with the routine operation of the facility or care of a particular resident. The occurrences were to be evaluated and investigated. Occurrences included skin tears. An Incident/Accident report form was to be completed and would include as applicable the date/time of the incident/accident, the nature of the injury, the circumstances surrounding the incident/accident, where the accident/incident took place, the names of the witnesses if observed, the resident ' s account if applicable, the time the resident ' s attending physician was notified as well as the time the physician responded and his/her instructions. Incident Report for Resident #365 dated 3/25/2025 at 11:00 PM by Registered Nurse #101, documented Licensed Practical Nurse #52 reported a skin tear on Resident #365 ' s right hand. Licensed Practical Nurse #52 told them the resident scraped their hand on their way in from the outside. Resident #365 stated they scraped their hand on the door coming in from outside. The wound was cleansed and dressed, and the provider was notified. Facility document titled, LN: Initial Event Documentation and dated 3/25/2025 at 11:00 PM by Registered Nurse #101, documented a new skin tear was noted to the right hand that was 1 centimeter and round. The resident reported they scraped their hand on the door on their way in from outside. The area was cleaned, and pressure applied to stop the bleeding. The wound was covered was covered with a dry sterile dressing. The Nurse Practitioner was notified and gave an order for a daily dressing. Facility document titled, Accident/Incident Statement Form – Licensed Nurse and dated 3/25/2025 at 11:00 PM by Licensed Practical Nurse #52, documented Resident #365 told them they scraped their hand on their way in from the outside. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence of a thorough investigation to determine how the accident/incident occurred and to protect the resident from recurrence. During an observation on 4/03/2025 at 1:19 PM, Resident #365 was noted to have a small scab on the knuckle of their right hand. During an interview on 4/03/2025 at 1:19 PM, Resident #365 stated they got their hand caught between the wheelchair grab bar and the right door frame on the main entrance to the facility when they were coming in from outside one night. They stated they rarely went out at late at night and then showed the surveyor a blank, Out on Pass Agreement, they had to complete prior to leaving the facility. During a subsequent interview on 4/04/2025 at 12:04 PM, Resident #365 stated someone let them out of the facility and back in on 3/25/2025. They could not recall who let them out/in and stated they were not sure if they completed and signed an Out on Pass Agreement that night. They could not recall why they went outside. During an interview on 4/07/2025 at 1:41 PM, Registered Nurse #101 stated they were the supervisor when Licensed Practical Nurse #52 told them that Resident #365 had a new skin tear. They stated it happened during change of shift at 11:00 PM on 3/25/2025. They stated Resident #365 was coming in from outside and hit their hand. They stated the resident was not supposed to be outside after 8:00 PM because there was no one at the front desk to let them out or back in. They stated they had no idea how the resident got outside and stated they did not ask the resident how they got out. They stated it was change of shift and said someone might have let him out/back in at that time. They stated they did not start an investigation to find out how the incident/accident happened. They stated they just checked the resident ' s skin and completed the incident/accident form. They stated happened at change of shift and they would have reported to the night supervisor. During an interview on 4/07/2025 at 2:17 PM, Director of Nursing #1 stated Resident #365 sustained an injury to their hand on 3/25/2025 that was resolved on 3/31/2025. They stated they would expect that an investigation be started immediately after identifying/treating the injury and said the supervisor should have asked the resident what they were doing outside, how they got outside and then back in, and where there leave of absence paperwork was. During an interview on 4/08/2025 at 12:08 PM, Licensed Practical Nurse #52 stated they recalled the incident with Resident #365 on 3/25/2025. They stated the resident came to them and showed them their hand that on a skin tear on it. The resident told them they hurt their hand when they were coming back into the building. Licensed Practical Nurse #52 stated they cleaned and dressed the wound and reported to Registered Nurse #101. They stated they did not let the resident out of the building that evening or any evening, since they never leave the unit once they started their shift. They stated they were new to the building and thought that there was always someone at the front desk to let people out/in. They stated they were aware the resident would leave the facility and usually would have a form for the nurse to sign. They had only signed one Out on Pass Agreement form for the resident and did not recall signing a form for the resident to leave the facility on 3/25/2025. They did not know who permitted the resident to go outside and did not know who let them back in. 10 New York Codes, Rules, and Regulations: 415.4(b)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the recertification survey and an abbreviated survey (Case #NY00358820), the facility did not ensure the development and implementation of comprehensive person-centered care plans that included measurable objectives and timeframes to meet the resident's medical, nursing, and psychosocial needs for 7 (Resident #s 14, 27, 38, 40, 211, 362, and 364) of 40 residents reviewed. Specifically, the facility did not ensure [a.] Resident #14 had a care plan developed for diagnoses of benign prostatic hyperplasia, obstructive uropathy, tremors, generalized anxiety disorder, and constipation, [b.] Resident #27 had a care plan developed for the use of a physician prescribed hormone cream, [c.] Resident #38 had a care plan developed for diagnoses of epilepsy and seizures, [d.] Resident #40 had a care plan developed for diagnosis of constipation, [e.] Resident #211 had a care plan developed to address self-performed oral suctioning as ordered by the physician, [f.] Resident #362 had a care plan developed to address the use of thigh high stockings for deep vein thrombosis (blood clot) prevention as ordered by the physician, and [g.] Resident #364 had a care plan developed for pain management. This is evidenced by: Cross-referenced to: F684: Quality of Care The Policy and Procedure titled, Care Plans-Comprehensive, revised 10/2019, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The care planning process would include an assessment of the resident's strengths and needs. The comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required comprehensive Minimum Data Assessment and would include measurable objectives and timeframes, describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and incorporate identified problem areas, reflect currently recognized standards of practice for problem areas and conditions. Resident #14: Resident #14 was admitted with diagnoses of Schizophrenia (a chronic mental illness characterized by symptoms such as hallucinations, delusions, and cognitive challenges), benign prostatic hyperplasia (prostate enlargement), and obstructive and reflux uropathy (a disorder of the urinary tract). The Minimum Data Set (an assessment tool) dated 11/30/2024, documented that the resident was cognitively intact, could be understood and could understand others. The Minimum Data Set, Quarterly assessment dated [DATE], Section I Active Diagnoses documented obstructive uropathy and benign prostatic hyperplasia with lower urinary tract symptoms. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Federally Mandated (60-day) Visit note dated 12/12/2024 by Provider #1, documented the resident received Flomax Capsule daily for benign prostatic hyperplasia, Miralax powder and Senna tablets daily for constipation, and Amantadine Capsule daily for tremors. Past medical and surgical history documented bowel resection (part of the intestine was removed). Assessment documented obstructive uropathy symptoms were controlled and generalized anxiety disorder was stable and was followed by psychiatry. The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for diagnoses of benign prostatic hyperplasia, obstructive uropathy, tremors, generalized anxiety disorder, and constipation. Resident #38: Resident #38 was admitted with diagnoses of bipolar disorder (mental illness that causes extreme mood swings), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness), and epilepsy (a chronic neurological condition characterized by recurrent seizures). The Minimum Data Set, dated [DATE], documented the resident, was severely cognitively impaired, could be understood, and understand others, and was dependent with activities of daily living. The Minimum Data Set, Quarterly assessment dated [DATE], Section I Active Diagnoses documented seizure disorder or epilepsy. The Order Summary Report for active orders as of 7/21/2024, documented a physician order dated 4/18/2024 for Valproic Acid Oral Solution 250 milligram/5 milliliters give 15 milliliters by mouth at bedtime for seizures. The Federally Mandated (60-day) Visit note dated 1/21/2025, documented the resident received Valproic Acid 750 milligram (used for epilepsy and bipolar disorder) daily at bedtime. The indication for use of the medication was not documented. Assessment documented bipolar disorder: currently depressed, mild, stable and was followed by psychiatry. There was no documentation about the resident's epilepsy diagnosis. The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for diagnoses of epilepsy and seizures. Resident #211: Resident #211 was admitted to the facility with diagnoses of cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively), malignant neoplasm of the lip, oral cavity, and pharynx (also known as cancer, is an abnormal growth of cells that can invade and spread to other parts of the body, specific to the lip, mouth and throat), and abdominal aortic aneurysm (a bulge or enlargement in the aorta). The Minimum Data Set (an assessment tool) dated 10/10/2024, documented the resident had moderately impaired cognition. The resident was able to make themselves understood and was able to understand others. The Order Summary Report for active orders as of 10/08/2024, documented and ordered dated 10/8/2024 for the resident to perform oral suctioning as needed every shift for excessive oral mucous. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Delmar Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 125 Rockefeller Road Delmar, NY 12054	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The LN: Admission/readmission Evaluation Part 1 dated 10/08/2024 by Registered Nurse #4, documented oral suctioning under the category of Respiratory Evaluation Concerns. The General Documentation Note dated 10/8/2024 at 8:00 PM by Registered Nurse #4, documented proper technique and education related to oral suctioning was provided to the resident. The resident was able to demonstrate proper technique when providing oral suctioning to self and the resident was able to teach-back education received related to oral suctioning. The resident was deemed appropriate for performing oral suctioning to self without supervision. The resident was encouraged to request assistance or ask questions when needed, the resident verbalized understanding. The Treatment Administration Record dated 10/1/2024 to 10/31/2024, documented the resident was to perform oral suctioning as needed every shift for excessive oral mucous. The treatment record was signed by the nurse as being done on 1/08/2024 during the evening shift, on 1/09/2024 during all 3 shifts, and on 1/10/2024 during the day shift. The Minimum Data Set, dated [DATE], Section O Special Treatments, Procedures, and Programs, documented scheduled suctioning was performed while a resident and within the last 14 days. The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for self-performed oral suctioning. During an interview on 1/21/2025 at 2:16 PM, Registered Nurse #1 stated that they participate care plan meetings. They would inform the social worker, providers and families of changes made to the plans of care. Additionally, Registered Nurse #1 stated that they did review comprehensive care plans but was not yet familiar with how to update them. They stated they had not been trained on how to review the care plans. Registered Nurse #1 stated that any medications that a resident take should have an International Classification of Diseases code and should be care planned for. During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that the Registered Nurses in the building update or create care plans. Stated a Licensed Practical Nurse could put interventions in place but could not initiate a new focus. If there was a new diagnosis or medication, there should have been a new care plan focus. Stated the Registered Nurse in the building at the time of the need for a care plan initiation or change was responsible for updating the care plan. During an interview on 1/23/2025 at 10:45 AM Director of Nursing #1 stated a resident who was permitted to self-suction would need to have a doctor's order and be assessed by nursing staff to be able to perform self-suctioning. They stated something should be in the resident's care plan for the ability to self-suction and intermittent monitoring should be done by nursing staff to ensure the resident was performing the procedure properly. They stated there should also be something in the medication and treatment administration records as well. 10 New York Code of Rules and Regulations 415.11(c)(1)

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Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview during the recertification and an abbreviated survey (Case #NY00364136), the facility did not ensure comprehensive care plans were reviewed and revised based on changing goals, preferences, and needs for 1 (Resident #s 6) of 40 residents reviewed. Specifically, the facility did not ensure Resident #6's comprehensive care plan was reviewed and revised when the resident fell and was assessed on 10/01/2024, 10/05/2024, 10/07/2024, 10/16/2024, 10/20/2024, 11/01/2024, 12/09/2024, and 12/11/2024. This is evidenced by: The Policy and Procedure titled, Care Plans-Comprehensive, revised 10/2019, documented assessments of residents were ongoing, and care plans were revised as information about the residents and the residents' conditions change. The Interdisciplinary Team reviewed and updated the care plan when there had been a significant change in the resident's condition, when the desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay, and at least quarterly, with scheduled quarterly Minimum Data Sets. Resident #6: Resident #6 was admitted to the facility with diagnoses of muscle weakness, pain, and fall. The Minimum Data Set (an assessment tool) dated 12/20/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others. Review of Incident Reports for Resident #6 dated October, November, and December 2024 documented the resident fell and was assessed with no injuries noted on 10/01/2024, 10/05/2024, 10/07/2024, 10/16/2024, 10/20/2024, 11/01/2024, 12/09/2024, and 12/11/2024. The Care Plan for Resident had an Actual Fall related to gait/balance problems, revised 10/30/2024, did include updates following the falls documented in Incident Reports dated October, November, and December noted above. During an interview on 1/23/2025 at 9:39 AM, Director of Nursing #1 stated that at the time of a fall the resident was immediately assessed, and interventions implemented to prevent further occurrence. They stated that the next day during the morning meeting, the resident's fall would be reviewed to ensure appropriate interventions were implemented and the resident's comprehensive care plan would be updated. 10 New York Code of Rules and Regulations 415.11(c)(2)(i-iii)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the recertification survey and an abbreviated survey (Case #NY00358820), the facility did not ensure residents receive treatment and care in accordance with professional standards of practice for 2 (Resident #s 34 and 211) of 40 residents reviewed for. Specifically, [a.] Resident #34 did not receive daily dressing changes per physician order, and [b.] the physician ordered for Resident #211 to self-perform oral suctioning as needed every shift for excessive oral mucous, however, facility policy for oral suctioning did not include a procedure and/or guidelines for self-performed oral suctioning, [c.] there was no documented evidence that Resident #211's vital signs were monitored and respiratory status assessed in accordance with professional standards of practice when the resident self-performed oral suctioning on 10/08/2024, 10/09/2024, and 10/10/2024. This is evidenced by: Cross-referenced to: F656: Develop/Implement Comprehensive Care Plan Cross-referenced to: F842: Resident Records - Identifiable Information Resident #34: Resident #34 was admitted to the facility with diagnoses of disruption or dehiscence (splitting open) of internal surgical wound of abdominal wall muscle, surgical aftercare, and personal history of malignant neoplasm (cancer) of the large intestine. The Minimum Data Set (an assessment tool) dated 1/2/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others. The policy and procedure titled, Wound Identification and Wound Rounds, revised 11/6/2023, documented the facility would identify, assess, and manage residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice. Record review of Resident #34's care plan section titled, Care Plan for Resident has Impaired Skin Integrity related to surgical abdomen, revised 1/9/2025, documented an intervention to apply treatment per physician order. During an observation on 1/13/2025 at 1:53 PM, Resident #34's abdominal dressing was noted with dry, brown-colored drainage and was dated 1/11/2025. Resident #34 stated they had abdominal surgery and had stitches. Stated that when they were in the previous rehabilitation facility, the wound opened, and they had to close it. Resident #34 stated they did not feel facility nursing staff was monitoring their incision and abdomen the way it should be. Record review of, Order Recap Report, dated 12/01/2024 to 1/31/2025, documented an order dated 12/23/2024 to cleanse abdominal wound with normal saline wet; pat dry with clean gauze; apply saline wet-to-moist gauze to wound bed; cover with abdominal pad; secure with dressing retention tape; every evening shift for wound care. Review of the Treatment Administration Record dated January 2025, documented the resident's abdominal wound treatment was administered by Licensed Practical Nurse #8 on 1/12/2025. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident 34's dressing change on 1/21/2025 at 12:39 PM, Resident #34's abdominal dressing was dated 1/20/2025. When asked about daily dressing changes, the resident stated staff have forgotten to change the dressing 3 or 4 times. The resident stated they had never refused a dressing change. Resident #34 stated there was a time when they reminded a male nurse on the evening shift that the dressing needed to get changed and the nurse said they were busy doing other things. Resident #34 stated the dressing did not get changed that evening. Resident #34 stated the male nurse was busy with this unit and had to run to the B/C unit. Resident #34 stated somebody reported the nurse about the dressing not being changed. Resident #34 stated that they wanted to report to the supervisor that their dressing was not being changed and a staff member (unknown) told them no, they would just change the dressing. During an interview on 1/23/2025 at 8:53 AM, Registered Nurse #2 stated they were not aware that Licensed Practical Nurse #8 had signed the Treatment Administration Record on 1/12/2025, but did not do the treatment. They stated they were not aware the resident had a concern about their dressing changes not being done. They stated the only time they knew the dressing was changed was on Monday 1/20/2025, during wound rounds. During an interview on 1/23/2025 at 9:39 AM, Director of Nursing #1 stated that the minute they found out the dressing was not changed on 1/12/2025, Licensed Practical Nurse #8 was written up and received a final warning. They stated Licensed Practical Nurse #8 documented the treatment was done on 1/12/2025, but did not change the dressing. During an interview on 1/23/2025 at 10:57 AM, Licensed Practical Nurse #8 stated that on 1/12/2025, there was a patient that needed to be sent to the hospital, and they were called off the unit. They stated they did click it as being done before it was done, and their intention was to go back in the room and change the dressing. Resident #211: Resident #211 was admitted to the facility with diagnoses of cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively), malignant neoplasm of the lip, oral cavity, and pharynx (also known as cancer, is an abnormal growth of cells that can invade and spread to other parts of the body, specific to the lip, mouth and throat), and abdominal aortic aneurysm (a bulge or enlargement in the aorta). The Minimum Data Set, dated [DATE], documented the resident had moderately impaired cognition. The resident was able to make themselves understood and was able to understand others. The Policy and Procedure titled, Suctioning - Oral Pharyngeal, revised 1/2020, documented the purpose of the procedure was to clear the upper airway of mucous and prevent the development of respiratory distress. Preparation for the procedure documented to obtain baseline vital signs from the resident's medical record. General guidelines documented to monitor the resident's vital signs during the procedure and discontinue and notify physician if resident showed signs of distress. Assessment documented to assess for the following signs and symptoms of respiratory distress: dyspnea (difficulty breathing or shortness of breath), gurgling or rattling breath sounds, cyanosis (a bluish color in the skin, lips, and nail beds caused by a shortage of oxygen in the blood), decreased oxygen level, restlessness, and/or obvious secretions or vomitus in the mouth. Steps in the Procedure documented to assess the respiratory status of the resident and effectiveness of the procedure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy did not include a procedure and/or guidelines for self-performed oral suctioning by a resident. Record review of the Order Summary Report for active orders as of 10/8/2024, documented an order dated 10/08/2024 for the resident to perform oral suctioning as needed every shift for excessive oral mucous. Record review of the Treatment Administration Record dated 10/01/2024 to 10/31/2024, documented the resident was to perform oral suctioning as needed every shift for excessive oral mucous. The treatment record was signed by the nurse as being done on 10/08/2024 during the night shift, on 10/09/2024 during all 3 shifts, and on 10/10/2024 during the day shift. There was no documented evidence on the Treatment Administration Record or Nursing Progress Notes that the resident's vital signs were monitored and respiratory status assessed in accordance with professional standards of practice when the resident self-performed oral suctioning on 10/08/2024, 10/09/2024, and 10/10/2024. During an interview on 1/23/2025 at 10:45 AM, Director of Nursing #1 stated a resident who was permitted to self-suction would need to have a doctor's order and be assessed by nursing staff to be able to perform self-suctioning. They stated something should be in the resident's care plan for the ability to self-suction and intermittent monitoring should be done by nursing staff to ensure the resident was performing the procedure properly. They stated there should also be something in the medication and treatment administration records as well. 10 New York Code of Rules and Regulations 415.12

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interviews during a recertification survey, the facility did not ensure each resident had an environment that was as free of accident hazards as was possible to prevent accidents for 1 (Resident #13) of 1 resident reviewed for accident hazards. Specifically, Resident #13 who shared a room with another resident was observed with medications in their room not supervised. This is evidenced by: Resident #13 was admitted to the facility with diagnoses of acute and chronic respiratory failure with hypoxia (when the body cannot exchange oxygen and carbon dioxide), type 2 diabetes mellitus without complications, and chronic obstructive pulmonary disease with (acute) exacerbation. The Minimum Data Set (an assessment tool) dated 11/12/2024 documented the resident was cognitively intact, could be understood and understand others. The Policy titled, Medication-Storage created 02/2014 last revised 01/2019 documented, The center would have Medications stored in a manner that maintained the integrity of the product, ensures the safety of the residents, and is in accordance with Department of Health guidelines. Procedures included that all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy. The Policy titled, Medication, Self- Administration created 03/2018 last revised 07/2019 documented Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Storage should be in a locked box in the resident's drawer and if safe storage is not possible in the resident's room, medications of residents permitted to self-administer would be stored on a central medication cart or in the medication room. During an observation on 01/13/2025 at 11:56 AM, an Albuterol inhaler (a prescription medication used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease) was noted to be present on the bedside table of Resident #13. Resident #13 was in a double occupancy room, with a roommate present in the other bed in the same room as Resident #13. The Albuterol inhaler was not stored in a safe and secure place, and was accessible to Resident #13 and to other residents. During an observation on 01/15/2025 at 10:25 AM, an Albuterol inhaler (as described above) and a Trelegy inhaler (a prescription inhaler used to treat asthma and chronic obstructive pulmonary disease) was noted to be present on the bedside table of Resident #13. Resident #13 was in a double occupancy room with a roommate present in the other bed in the same room as Resident #13. The Albuterol inhaler and the Trelegy inhaler were not stored in a safe and secure place, and they were accessible to Resident #13 and other residents. During an interview on 01/15/2025 at 10:25 AM, Resident #13 stated the nurses left the inhalers on their bedside table throughout the day and at the end of the day after the last time it was used, they stored it on the cart. They stated in the next morning, sometimes the nurses would leave the inhalers on their bedside table, or they may store them on the medication cart. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/21/2025 at 10:12 AM, Director of Nursing #1 stated there was no resident in the building that administered their own medications. They stated if a resident was not capable to administer their own medications independently but could do so with supervision, residents should not have access to the medications until it was provided by nursing. 10 New York Codes, Rules, and Regulations: 415.12 (h)(2)

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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.

Based on observation, record review, and interviews during a recertification and abbreviated survey (Case #s NY00358820 and NY00359065), the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's staffing minimum staffing levels were not met each day from 1/12/2025 through 1/17/2025 per facility assessment and New York State Nursing Home Minimum Staffing and Direct Resident Care.

This is evidenced by:

Upon entrance to the facility on 1/12/2024 there were 118 residents residing on 3 units.

Nursing Homes are required by New York State Public Health Law and Regulations to meet minimum staffing standards. These minimum standards required every nursing home to maintain daily staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, licensed practical nurse, or registered nurse. Of the 3.5 hours required, at least 2.2 hours of care per resident per day must be provided by a certified nurse aide and at least 1.1 hours of care per resident per day must be provided by a licensed nurse.

The facility assessment dated 1/2025 documented that the staffing plan was based on the resident population and their needs for care and support. The staffing plan documented the following daily staffing needs:

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Shift, Category of Staff, Number of Staff, Total Hours Worked

Days, Registered Nurse, 1-4, 7.5-30

Days, Licensed Practical Nurse, 3-6, 22.5-45

Days, Certified Nurse Aide, 6-14, 45-105

Evenings, Registered Nurse, 0-1, 0-7.5

Evenings, Licensed Practical Nurse, 3-6, 22.5-45

Evenings, Certified Nurse Aide, 6-12, 45-90

Nights, Registered Nurse, 0-1, 0-7.5

Nights, Licensed Practical Nurse, 2-3, 15-22.5

Nights, Certified Nurse Aide, 3-8, 22.5-60

[Note: Where Days = 7 AM to 3 PM, Evenings = 3 PM to 11 PM, Nights = 11 PM to 7 AM]

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

**

A review of staffing sheets provided by the facility from 12/01/2024 through 1/11/2025 documented the following:

Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 12/07/2024, 12/14/2024, 12/28/2024, 12/31/2024, and 1/05/2025.

On 12/07/2024, the facility census was 118. There were 15 licensed nurses (Licensed Practical Nurses and Registered Nurses) scheduled to work on that day. The required hours of licensed care for the facility were 129.8 hours based on the census. The licensed staff scheduled accounted for 120 hours of care.

On 12/14/2024, the facility census was 119. There were 16 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 130.9 hours based on the census. The licensed staff scheduled accounted for 128 hours of care.

A review of staffing sheets provided by the facility from 1/12/2024 through 1/17/2025 documented the following:

Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 1/12/2025 and 1/17/2025.

To fulfill the staffing requirement for licensed nursing care (Registered Nurses and Licensed Practical Nurses) per resident per day, a facility with a census of 118 would need to schedule at least 17 staff members with nursing licenses for the entire day.

**

Date, Facility Census, Scheduled Staff, Actual Scheduled Hours, Required Staffing Hours

01/12/2025 ,118 ,10 ,80 ,129.8

01/13/2025 ,118 ,17 ,136 ,129.8

01/14/2025 ,118 ,18 ,144 ,129.8

01/15/2025 ,118 ,19 ,152 ,129.8

01/16/2025 ,118 ,19 ,152 ,129.8

01/17/2025 ,118 ,16 ,128 ,129.8

**

Based on facility census, there were not the required number of Certified Nurse Aides on any day between 1/12/2025 and 1/17/2025.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	To fulfill the staffing requirement for Certified Nurse Aide care per resident per day, a facility with a census of 118 would need to schedule at least 37 staff members with nurse aide certifications for the entire day. ** Date, Facility Census, Scheduled Staff, Actual Scheduled, Required Staffing Hours 1/12/2025, 118, 14, 112, 289.1 1/13/2025, 118, 26, 208, 289.1 1/14/2025, 118, 31, 248, 289.1 1/15/2025, 118, 30, 240, 289.1 1/16/2025, 118, 29, 232, 289.1 1/17/2024, 118, 23, 184, 289.1 ** A review of punch cards provided by the facility from 1/12/2024 through 1/17/2025 documented the following: To fulfill the staffing requirement for licensed nursing care (Registered Nurses and Licensed Practical Nurses) per resident per day, a facility with a census of 118 would have at least 17 staff members with nursing licenses registered as working the entire day. Per the punched timecards, and based on the facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 1/12/2025 or 1/17/2025. ** Date, Facility Census, Staff Timecard Punches, Actual Scheduled Hours, Required Staffing Hours 1/12/2025, 118, 12, 96, 129.8 1/13/2025, 118, 19, 152, 129.8 1/14/2025, 118, 22, 176, 129.8 1/15/2025, 118, 25, 200, 129.8 1/16/2025, 118, 23, 184, 129.8 1/17/2025, 118, 14, 112, 129.8 ** (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335735	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

To fulfill the staffing requirement for Certified Nurse Aide care per resident per day, a facility with a census of 118 would need to schedule at least 37 staff members with nurse aide certifications for the entire day. Per the punched timecards, and based on the facility census, there were not the required number of Certified Nurse Aides on any day between 1/12/2025 and 1/17/2025.

Date, Facility Census, Staff Timecard Punches, Actual Scheduled Hours, Required Staffing Hours

1/12/2025, 118, 16, 128, 289.1

1/13/2025, 118, 23, 184, 289.1

1/14/2025, 118, 21, 168, 289.1

1/15/2025, 118, 26, 208, 289.1

1/16/2025, 118, 19, 152, 289.1

1/17/2025, 118, 13, 104, 289.1

During a Resident Council Meeting on 1/14/2025 at 11:07 AM observed by the New York State Department of Health survey team, five out of five residents expressed concerns related to staffing in the building. When asked if they got the help and care they needed without waiting a long time and if staff responded to their call light timely, residents stated they did not, and it could take a good hour for call lights to be answered. The residents noted that it took longer for the call lights to be answered at nighttime. The residents' stated staffing was a disaster on the weekends.

During an interview on 1/14/2025 at 9:32 AM Family Member #3stated that they had concerns with staffing, particularly on the weekends. The Family Member #3 further stated that they provide personal care and ambulation assistance because staff were not providing the care.

During an interview on 1/17/2025 at 11:23 AM, Staffing Coordinator #1 stated that they put their schedule in place months in advance and gave it to upper management for review. At the time of the interview, Staffing Coordinator #1 stated they had completed the staffing schedule through May 2025. Every Tuesday and Thursday, upper management and Staffing Coordinator meet to discuss any issues with the schedule as it was written.

Additionally, the Staffing Coordinator #1 stated that the Director of Nursing should not be in an assignment, but it has happened. It most recently happened over the holidays. Staffing Coordinator #1 stated they used travel nurses or borrow from other corporate facilities. Borrowing from another corporate facility was a last resort.

During an interview on 1/21/2025 at 2:02 PM Licensed Practical Nurse #1 stated that they worked alone the day before and there was not enough staff at the facility. Licensed Practical Nurse #1 stated that they struggled to complete all their work, but they loved the residents, so they stay even though the work was difficult.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Center for Rehabilitation and Nursing	125 Rockefeller Road Delmar, NY 12054

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 1/21/2025 at 2:16 PM Registered Nurse #1 stated that there was never enough staff to give everyone the ability to do their job effectively, but they had only been employed at the facility a little over a month and was still learning. During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that they had been the Director of Nursing for 3 months and employed at the facility for 9 months. Director of Nursing #1 stated that it was hard to recruit staff because the pay structure was not good, but the facility was working with the union to increase the amount that can be offered to staff. During an interview on 1/23/2025 at 11:03 AM Administrator #1 stated that they used to recruit for the whole building and beginning on 1/06/2025, corporate also started helping with staff recruitment. Administrator #1 stated they spend 2-3 hours a day trying to get staff hired or interviewed. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER: Delmar Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 Rockefeller Road Delmar, NY 12054	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents were free of any significant medication errors for 1 (Resident #s 62) of 40 residents reviewed. Specifically, Resident #62 was not given Alprazolam (used to treat anxiety) at the prescribed therapeutic times. Additionally, there was no documented evidence that physician was notified, and that Resident #62 was monitored for side effects. This is evidenced by: Resident # 62 was admitted to the facility with diagnoses of pubic ramus fracture (a fracture of the pubic bone), primary osteoarthritis (arthritis of the bones and joints), left shoulder, and muscle weakness. The Minimum Data Set (an assessment) dated 12/24/2024 documented the resident had intact cognition, could be understood, and understand others. The facility's Policy and Procedure titled Medication Administration revised 12/2019, documented medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label three (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication. During an interview on 01/14/2025 at 11:40 AM, Resident #62 stated the night nurse came in a week ago and gave Tylenol and Alprazolam (Xanax) at 5:30 PM. They came in again at 7:30 PM to give their night pills including another Xanax. When Resident #62 refused, Nurse left the pills on the table and told resident take them or not, I don't care. The Medication Administration Record dated 12/17/2024 through 1/15/2025 documented give Alprazolam 0. 5 milligrams at 09:00, 16:00, and 21:00. The Physician's order dated 12/18/2024 documented give Alprazolam 0.5 milligram 1 tablet by mouth three times a day for anxiety. The Physician's order dated 12/18/2024 documented give Alprazolam 0.5 milligram 1 tablet by mouth every eight hours as needed for anxiety for 14 days. Order was discontinued on 1/1/2025. Resident received one as needed dose on 12/18/2024 at 11:02 AM. On 12/18/2024: 09:00 dose was not administered. 11:02 AM Resident received as needed dose. 16:00 dose administered at 18:33 - given 2 ½ hours late 21:00 dose administered at 20:08 - given 1 hour early, and 2 hours after previous dose. On 12/24/2024: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335735	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER: Delmar Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 125 Rockefeller Road Delmar, NY 12054	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Alprazolam 0.5 milligram ordered at 16:00 and 21:00 were administered at 17:23 and 20:30 respectively. Medication given three hours apart. On 12/26/2024: Alprazolam 0.5 milligram ordered at 16:00 and 21:00 were administered at 17:52 and 20:37 respectively. Medication given 2 hours and 15 minutes apart On 12/28/2024: Alprazolam 0.5 milligram ordered at 09:00 AM. Administered at 12:00 PM. Given 3 hours late. On 1/02/2025: Alprazolam 0. 5 milligram ordered at 16:00 and 21:00 were administered at 16:57 and 20:03 respectively, 3 hours and 6 minutes apart. On 1/04/2025: Alprazolam 0.5 milligram ordered for 16:00 and 21:00 were administered at 17:24 and 20:34 respectively, 3 hours and 10 minutes apart. On 1/06/2025: Alprazolam 0.5 milligram ordered for 16:00 and 21:00 were administered at 17:20 and 20:20 respectively, 3 hours apart. During an interview on 01/16/2025 at 10:45 AM, Director of Nursing #1 stated nursing staff received new hire orientation including medication administration. They stated Nurses were assigned a preceptor who completed the orientation checklist of skills. A medication pass was demonstrated with competency prior to signing off checklist. The 5 rights of medication administration per policy were to be followed including right time that medication was administered. They stated if a medication was given late the physician should be notified. During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse # 3 stated all medications should be given as ordered by the physician and written in the Medication Administration Record. They stated the Unit Manager checked the dashboard to determine whether the medications were given, and at the end of the month the unit manager checked that all medications were signed for on the Medication Administration Record. During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #4, (Unit Manager) and Licenses Practical Nurse #3 stated they agree that administering Xanax at 18:33 and then again at 20:08 was a medication error. Both stated they were unaware of the Xanax medication errors. 10 New York Codes, Rules, and Regulations 415.12(m)(2)