STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335737	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Lawrence Care Center, L L C	1410 Seagirt Blvd Far Rockaway, NY 11691

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Recertification and Complaint Survey from 07/28/2025 to 08/04/2025, the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident during review of Staffing, Residents' food preferences, Dignity, Home like Environment, Resident Assessment, and Abuse, 1.) The Administration did not ensure the facility was sufficiently staffed to meet the residents' needs, residents' assessments were accurate, and their dietary preferences met. In addition, the Administration did not monitor and enhance the quality of care and services as indicated by repetition of deficiencies that were cited on previous recertification surveys {F584 and F657} 2.) Nursing Services were not administered adequately to ensure that residents rights and preferences were provided to the residents, that home like environment were maintained, and that participation in care planning occurred. The findings are:The facility's policy titled Quality Assurance and Performance Improvement of [NAME], effective 1/1/22, last reviewed 02/25, documented that Quality assurance performance improvement principles will drive the decision making within the organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care and resident transitions. 1. Refer to citation F577, F582, F584, F600, F609, F627, F675, F725, F813, and F921On 08/04/2025 at 4:09 PM, the Administrator was interviewed and stated they were not aware of any environmental issues, the residents' food preferences, nor that there were concerns about dietary preferences as there were never any complaints made about resident's food choices and preferences. The Administrator also stated they were aware that sufficient nursing staffing was an issue and nursing staff are given incentives to pick up other shifts, and that there was an oversight in not posting all surveys. The Administrator further stated they aware of a resident's discharge to the hospital but did not consider it an issue. monitored to prevent recurrence. The Administrator was interviewed for Quality Assurance and stated that meetings for Quality Assurance are held monthly, where several topics are discussed. 2. Refer to citation F550, F553, F584, F600, F641, F657, F692, F725On 08/04/2025 at 4:09 PM, the Director of Nursing was interviewed and stated they were unaware of the extent of the staffing issues but was aware that agency staff posed a challenge. The Director of Nursing also stated they were aware of the resident's rights as it pertains to F550, and F553, however was not aware that it impacted resident care and services. The Director of Nursing further stated they were aware of the inaccuracies of residents' assessments, but did not consider it egregious and this and the staffing issue were discussed in the Quality Assurance meetings. The Director of Nursing stated they were unaware of the issues identified in F584, F600, F657, and F675, indicating lack of oversight. The Director of Nursing also stated they have implemented a number of initiatives, and the Maintenance and Nursing team do rounds on the units, to address any areas that are in need of attention. 10 NYCRR 415.26

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record the facility did not ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Specifically, the facility policy and practices did not honor resident's food preferences and required all residents to consume Kosher meals. In addition, residents were permitted to consume outside food or meals prepared or brought in by family members unless prior arrangements were made with facility staff. When outside food was permitted, residents were not allowed to consume these foods in an area of the facility of their own choosing as this food could only be consumed in the Recreation area. Residents were only permitted to purchase outside food once weekly with their own funds. This resulting in residents experiencing dissatisfaction with their dining experiences and restricted access to individual resident food preferences for those without the means to pay for their own food.The findings are: The facility assessment updated 6/13/2025 documented [NAME] Care Center will provide food and nutrition choices to meet the personal preference of patients and [NAME] will take into account the personal preferences of patients and residents. The facility has a bed capacity of 215 beds. The census at the time of the survey was 158 residents. The undated Resident Handbook stated [NAME] Care Center is a strict kosher facility. No Non-Kosher food of any kind may be brought into the facility. Additionally, meat products and milk products may not be consumed at the same time. For further explanation of the kosher dietary laws speak with the Social Services Department. The Civil Rights Questionnaire dated 07/28/2025 documented a census of 158 residents 14 residents of Jewish religious affiliation. On 07/28/2025 on entrance into the facility at 9:00 AM there was a sign observed on the outer door and lobby door of the facility which stated No outside food is permitted in the facility at any time. Thank you for your corporation [NAME] Administration. On 07/28/2025 at 10:58 AM, Resident #153 was interviewed and stated their family cannot bring food for them to eat and they cannot eat the food in their room. Resident #153 also stated when their child does bring them food, and they have to take the food back home with them. On 07/31/2025 at 10:22 AM, Resident #47 stated they get food from outside on Friday such as pizza. Resident #47 also stated that they were told that they cannot have outside food and family and friends do not bring them food and if they do they must have it in the dining room as they cannot bring it to the unit. During an interview on 07/31/2025 at 10:26 AM, Resident #96 stated they have been in the facility a few months and they were informed it was a kosher facility prior to coming. Resident #96 also stated they once ordered outside food but cannot afford to do this all the time as they would have to pay for it with their own money. On 07/31/2025 at 12:30 PM, the Registered Dietitian #1 was interviewed and stated resident are (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	allowed outside food in a room downstairs in the Recreation room eating foods. Registered Dietitian #1 also stated the facility has kosher food and residents are not supposed to have food on the unit. During an interview on 07/31/2025 at 01:17 PM, the Food Service Administrator stated the patient population of the facility is predominantly African American and Spanish patients. The Food Service Administrator also stated the residents/resident representatives are made aware that the facility is a kosher facility. The Food Service Administrator further stated residents can have outside food, but they have to make a reservation for the food usually with the Recreation, or Nurse supervisor and the resident would have to eat in the Recreation room with the visitor. The Food Service Administrator stated residents are allowed to have outside food every Friday and can order Chinese or Italian food or bacon cheeseburgers. On 08/01/2025 at 12:32 PM, Resident Representative #1 for Resident #153 was interviewed and stated that they have tried to bring food from home for Resident #153 to consume and they have had to take it back home with them because they were not allowed to provide or bring outside food to the resident without prior approval from the facility. On 08/01/2025 at 12:33 PM, Resident #153 was re-interviewed and stated they were not allowed to bring outside food into the facility or consume outside food in the facility. Resident #153 also stated they were informed about the outside food, but this is different because at other facilities they were able to bring food into the building. Resident #153 further stated once they got takeout food on a family visit, and they were allowed to consume the food outside the building as they don't allow outside food in here. Resident #153 stated their fiancé cooks home cooked meals for them and they are craving outside food. Resident #153 further stated their family brought them food and they thought the family room area or cafeteria would be available, but they were told they could not eat in there because no food other than kosher food was allowed in the facility. On 8/4/2025 at 11:15AM, Resident #90 was interviewed, and stated the food here is horrible and they do not like the food, and they cannot get the foods they want. Resident #90 further stated they were told the facility was kosher 3 years ago, and they would like to be able to buy their own food, but they have to suffer along with the facility rule. On 08/04/2025 at 11:21 AM, Resident #133 stated their family brings food from home, and they have to eat it in the Recreation room. On 08/04/2025 at 11:24 AM, Resident #84 was interviewed and stated the food here is terrible and they do not let you bring in any food. Resident #84 also stated they were informed the facility is kosher, but they do not like the food, and they are thinking about transferring someplace else because they cannot eat the food. Resident #84 further stated they want food they can eat, regular food, and they are not asking for too much from the facility. During an interview on 08/04/2025 at 12:43 PM, Resident #83 stated they were informed the facility was kosher 4 weeks ago and they eat the food because they are starving. Resident #83 also stated their family, and friends bring them food, but they have to eat it downstairs. On 08/04/2025 at 12:53 PM, Resident #26 was interviewed and stated they were not informed that the facility was kosher, and they are not allowed to get food from outside. Resident #26 also stated their family can bring them food, but they have to make an appointment/reservations to bring them the food. Resident #26 further stated they cannot have cheese on their burgers, and everyone is (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asking for cheese for their burgers. During an interview on 08/04/2025 at 1:46 PM, Recreation Aide #1 stated they monitor the recreation room for visitors up to 2 times a week when visitors bring outside food for residents. Recreation Aide #1 also stated they make sure that the room is set up, the suction machine is plugged in and if a resident has a choking emergency that there is someone close by. Recreation Aide #1 further stated residents are offered take out on Fridays and they can order Chinese food, pizza or food from the deli. Recreation Aide #1 stated family are able to bring their own personal food, and it has to be eaten in the recreation room. During an interview on 08/04/2025 at 1:20 PM, the Rabbi stated the building is strictly kosher and most kosher facilities allow no outside food, as no outside food is allowed where kosher foods are served. The Rabbi also stated there are times family/visitors can make arrangement for outside food, and non-kosher foods are not allowed in the resident dining room or resident rooms. The Rabbi also stated that there is a Friday program where residents are offered to buy takeout food which is eaten in the recreation room, and this has been in place to offer residents the opportunity to have food supervised with Recreation and Social Work involved. Resident#12 admitted to the facility with diagnoses that include Coronary Artery Disease, Hypertension, End Stage Renal Disease and Hemiparesis. The admission Minimum Data Set, dated [DATE] documented Resident #12's cognition as intact, very important to have snacks available between meals and have family or close friend involved in discussions about their care. On 07/29/2025 at 12:20 PM, Resident #12 was interviewed and stated they do not like the food and that they are not allowed to bring in any food. Resident #12 also stated 3 weeks ago their child brought some Jello cups for them, which were confiscated by the staff, and they were told it is a Kosher facility, and the Jello was not returned. Resident #12 further stated they are not Kosher, so they do not understand why they can't eat their own food. On 07/30/2025 at 11:00 AM, during the Resident Council meeting, Resident #26 stated that stated that their food is not allowed in the facility. Resident #26 also stated they are not kosher, and are not allowed to bring in food, so they cannot have their food when they want. On 07/30/2025 at 11:00 AM, during the Resident Council meeting, Resident #123 stated they can only order food on Fridays and that it is Chinese and Italian only. Resident #123 also stated they do not like the food here and only eat lunch and dinner when they can order the food on Fridays. On 08/01/2025 at 10:48 AM, Registered Nurse Supervisor #2 was interviewed and stated the residents are aware that food cannot be brought in from the outside, however, the residents can order food from any place that delivers, and it's facilitated by the Recreation department. Registered Nurse Supervisor #2 also stated food is ordered once a week by the Recreation department only, but if the family wants to bring in food, they must call the Social Worker ahead of time, and they will schedule a place on the 1st floor where it can be eaten in a designated area only. On 08/01/2025 at 10:54 AM, the Dietician was interviewed and stated if residents want food from outside, the facility can arrange to have the food eaten in a specific area and the cannot eat it in their room. The Dietician also stated that the facility can order for them from a few restaurants, however (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents must pay for their own food. On 08/01/2025 at 11:11 AM, the Activities Director who is also the Social Work Director was interviewed and stated the administration gives them items and menus that are available on Fridays, from which the residents can order food from. The Activities Director also stated residents are not allowed to order from the outside, and there no food can be delivered. The Activities Director further stated residents can have food brought in from outside, and families can bring the food, but they recommend appointments first, because it can only be eaten on the 1st floor, and they must ensure the availability of the families, for spacing in the dining room. The Social Worker Director stated that they only order the food for the residents on a Friday, because that is how the policy is written. On 08/04/25 at 4:00PM, the Administrator was interviewed and stated that the facility is a Kosher facility, and they have instituted a program whereby once a week, the residents could purchase food from the outside, through the Recreation department. The Administrator also stated that this a supervised program, and the policy is part of the admission agreement and in the accommodations, and that families and visitors can have the non-kosher food in the recreation and conference room, on the 1st floor. The Administrator further stated residents and families can make special requests if the residents are unable to leave their room whereby the facility will make sure that there is no food in the room besides the food brought in into the room, to maintain the kosher rule. The Administrator stated they are not aware that there were any issues with the rule. 10 NYCRR 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of the facility Daily Staffing Reports and Payroll Based Journal Staffing Data Report of Quarter 2 2025 (January 1 to March 31) which indicated Excessively Low Weekend Staffing and One Star Staffing Rating, it was determined that the facility did not ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. The findings include: The Facility assessment dated [DATE] documented there were 43 beds on each floor from 3rd to 6th floor. The Facility Assessment revealed the par level was 1 Registered Nurse for each floor on the Day shift from 7:00 AM-3:00 PM and 1 Registered Nurse for whole facility for Evening shift 3:00 PM-11:00 PM and Night shift 11:00 PM-7:00 AM. The Facility Assessment also documented there were 1.5 Licensed Practical Nurses on the 3rd, 4th, and 6th floor and 1 Licensed Practical Nurse on the 5th floor for Day shift, and 1 Licensed Practical Nurse on each floor for the Evening and Night shift. The Facility Assessment further documented each floor should have 4 Certified Nursing Assistants for the Day shift, 3 Certified Nursing Assistants for the Evening shift, and 2 Certified Nursing Assistants for the Night shift. The weekend Daily Staffing sheets from 01/04/2025 to 03/30/2025 provided by the facility revealed the following: 1 Registered Nurse for the whole facility during the Day shift instead of 1 Registered Nurse for each floor for day shift as the par level indicated. There was no 0.5 Licensed Practical Nurse working on Sunday 01/05/2025, Sunday 01/19/2025, Saturday 01/25/2025, Sunday 01/26/2025, Sunday 02/09/2025, Sunday 03/09/2025, Sunday 03/16/2025, and Sunday 03/23/2025. On Saturday 01/04/2025, Day shift, the 6th floor had 3 Certified Nursing Assistants which was below the par level of 4 Certified Nursing Assistants on each floor. On Sunday 01/05/2025, Evening shift, there was no Licensed Practical Nurse on the 5th floor, and 1 Certified Nursing Assistant on 5th and 6th floor which was below par level of 1 Licensed Practical Nurse per floor and 3 Certified Nursing Assistants on each floor.On Sunday 01/12/2025, Evening shift, there were 2 Certified Nursing Assistants on the 3rd floor and 1 Certified Nursing Assistant on the 4th, 5th, and 6th floor, which was below the par level of 3 Certified Nursing Assistant on each floor. On Sunday 01/19/2025, Night shift, there was 1 Certified Nursing Assistant on the 3rd, 4th, 5th, and 6th floor which was below the par level of 2 Certified Nursing Assistants for each floor. On Saturday 02/01/2025, Day shift, there were 3 Certified Nursing Assistants on the 5th floor, which was below the par level of 4 Certified Nursing Assistants for each floor. On Sunday 02/02/2025, Evening shift, there were 2 Certified Nursing Assistants on the 6th floor, which was below the par level of 3 Certified Nursing Assistants on each floor. On Sunday 02/09/2025, Evening shift, there 2 Certified Nursing Assistants on the 6th floor, which was below the par level of 3 Certified Nursing Assistants on each floor. On Sunday 02/09/2025, Night shift, there was 1 Certified Nursing Assistant on the 6th floor, which was below the par level of 2 Certified Nursing Assistants on each floor. On Saturday 02/15/2025, Evening shift, there were 2 Certified Nursing Assistants on the 6th floor, which was below the par level of 3 Certified Nursing Assistants on each floor.On Sunday 02/23/2025, Day shift, there were 3 Certified Nursing Assistants on the 5th floor, which was below the par level of 4 Certified Nursing Assistants for each floor. On Sunday 02/23/2025, Night shift, there was 1 Certified Nursing Assistant on the 3rd, 4th, and 5th floor which was below the par level of 2 Certified Nursing Assistants for each floor. On Sunday 03/02/2025, Day shift, there were 3 Certified Nursing Assistants on the 3rd floor, which was below the par level of 4 Certified Nursing Assistants for each floor. On Sunday 03/02/2025, Evening shift, there 2 Certified Nursing Assistants on the 4th floor, which was below the par level of 3 Certified Nursing Assistants on each floor. On Saturday 03/08/2025, Night shift, there was 1 Certified Nursing Assistant on the 4th floor, which was below the par level of 2 Certified Nursing Assistants for each floor. On Sunday 03/09/2025, Day shift, there were 3 Certified Nursing Assistants on the 4th and 5th floor, which was below the par level of 4 Certified Nursing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistants for each floor. On Sunday 03/09/202, Night shift, there was 1 Certified Nursing Assistant on the 3rd floor which was below the par level of 2 Certified Nursing Assistants for each floor. On Sunday 03/23/2025, Day shift, there were 3 Certified Nursing Assistants on the 3rd floor, which was below the par level of 4 Certified Nursing Assistants for each floor. On Saturday 03/29/2025, Day shift, there were 3 Certified Nursing Assistants on the 6th floor, which was below the par level of 4 Certified Nursing Assistants for each floor. On Sunday 03/30/2025, Night shift, there was 1 Certified Nursing Assistant on the 3rd floor which was below the par level of 2 Certified Nursing Assistants for each floor. On 08/01/2025 at 10:03 AM, Certified Nursing Assistant #3 was interviewed and stated staffing was short most weekends when some staff called out. Certified Nursing Assistant #3 also stated the agency Certified Nursing Assistants called out on the weekends most of time. Certified Nursing Assistant #3 further stated there should be 4 Certified Nursing Assistants on the unit for day shift. Certified Nursing Assistant #3 stated when someone called out and no replacement was made, they had extra residents to take care of on their shift. Certified Nursing Assistant #3 also stated residents had to wait longer for care and stayed in bed instead of transferring out to the wheelchair when there was short staff. On 08/01/2025 at 1:39 PM, Certified Nursing Assistant #4 was interviewed and stated there were only 3 instead of 4 Certified Nursing Assistant working on the unit for the day shift if the facility was unable to find a replacement aide when someone called out. Certified Nursing Assistant #4 also stated residents had to wait longer time for care and stayed in bed when they were short in staffing. On 08/01/2025 at 1:48 PM, Certified Nursing Assistant #5 was interviewed and stated staffing was short for the weekends. Certified Nursing Assistant #5 also stated there were only 2 instead of 4 Certified Nursing Assistants sometimes for day shift when staff called out. Certified Nursing Assistant #5 stated they tried their best and were not able to bring all residents out of bed and residents had to wait a longer time for care when staffing was short.On 08/04/2025 at 11:04 AM, the Director of Nursing was interviewed and stated they were covering Staffing Coordinator since June 2025 and the newly hired Staffing Coordinator was in training. The Director of Nursing also stated they started working at the facility on 03/24/2025 and was not aware of the staffing shortage issue for the period 01/01/2025 to 03/31/2025. The Director of Nursing further stated the Registered Nurse Supervisor for the shift called the staff not scheduled to work for overtime when scheduled staff called out or did not report to work. The unit would be short of staff if the Registered Nurse Supervisor was not able to get replacement staff. The Director of Nursing stated they had orientation for Certified Nursing Assistant every week now to bring more staff in. The Director of Nursing also stated there should be 1 Registered Nurse for the Day shift for the whole facility but not for each floor. The Director of Nursing had no explanation why the facility assessment documented there should be one Registered Nurse for each floor during the Day shift. The Director of Nursing stated the 0.5 out of the 1.5 Licensed Practical Nurse on the 3rd, 4th, and 6th floor referred to a treatment nurse for wound care. The Director of Nursing was not able to explain why the treatment nurse added up to 1.5 Licensed Practical Nurse in the facility assessment. The Director of Nursing also stated the Registered Nurse had to cover the Licensed Practical Nurse for medication administration or wound care if they were short of Licensed Practical Nurses. The Director of Nursing further stated the Registered Nurse called them to report and then either the Assistant Director of Nursing or themselves would come to facility to cover the Registered Nurse role. On 08/04/2025 at 11:40 AM, the Administrator was interviewed and stated they were not aware of a staffing shortage issue for weekend and the Payroll Based Journal triggered for Excessively Low Weekend Staffing and One Star Staffing Rating for the Fiscal Year Quarter 2, 2025 (January 1 - March 31). The Administrator also stated there would be short staffing when someone called out and no replacement was made. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during a Recertification survey, the facility did not ensure that they had a policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Specifically, the facility policy did not ensure that facility staff were able to assist residents in accessing and consuming food brought from outside, and did not permit storage of food brought in by family or visitors. Based on observation, record review and interviews conducted during a Recertification survey, the facility did not ensure that they had a policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Specifically, the facility policy did not ensure that facility staff were able to assist residents in accessing and consuming food brought from outside, and did not permit storage of food brought in by family or visitors. The finding is: The facility policy and procedure dated 01/2025 titled Use and Storage of Food and Beverage Items Brought to the Facility stated as a Kosher Certified Facility it is the policy of [NAME] Care Center to ensure food and beverages prepared in accordance to and to the highest possible levels of both Jewish religious dietary laws and food safety standards. No food or drink may be brought and stored into the facility by family members and or visitors without prior consent of the Administration. Residents and/or representatives will be educated on the policy and procedure related to food and beverage items brought into the facility upon admission, and as needed during resident and family council meetings. Employees including contractual staff will be educated on the policy and procedure upon hire and annually. Specially prepared or alternative food (other than Kosher food) or food required by a therapeutic or modified diet prescribed by a physician will be discussed with the interdisciplinary team and Administration prior to implementation. Family members or visitors should inform and discuss with the Social Workers/Designated Representative of their desire to bring food and beverages prepared from outside. Family members or visitors with food items approved by administration must consume the food items in the recreation office/designated area. Any food prepared outside the facility can only use or be served with utensils brought from outside the facility. Nursing staff will monitor resident rooms, unit pantry and refrigeration units for food and beverages not prepared by the facility for disposal. Any unlabeled and undated foods and beverages must be immediately discarded. The facility assessment updated 6/13/2025 documented [NAME] Care Center will provide food and nutrition choices to meet the personal preference of patients and [NAME] will take into account the personal preferences of patients and residents. The facility has a bed capacity of 215 beds. The census at the time of the survey was 158 residents. The undated Resident Handbook stated [NAME] Care Center is a strict kosher facility. No Non-Kosher food of any kind may be brought into the facility. Additionally, meat products and milk products may not be consumed at the same time. For further explanation of the kosher dietary laws speak with the Social Services Department. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Lawrence Care Center, L L C	1410 Seagirt Blvd Far Rockaway, NY 11691

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Civil Rights Questionnaire dated 07/28/2025 documented a census of 158 residents 14 residents of Jewish religious affiliation. On 07/28/2025 on entrance into the facility at 9:00 AM there was a sign observed on the outer door and lobby door of the facility which stated No outside food is permitted in the facility at any time. Thank you for your corporation [NAME] Administration. On 07/28/2025 at 10:58 AM, Resident #153 was interviewed and stated their family cannot bring food for them to eat and they cannot eat the food in their room. Resident #153 also stated when their child does bring them food, and they have to take the food back home with them. On 07/31/2025 at 10:17 AM, the [NAME] was interviewed and stated since working here they have not been allowed to bring in outside food. The [NAME] also stated only kosher food is allowed in the kitchen, there are a meat and a dairy side of the kitchen so there is no mixing of food. On 07/31/2025 at 10:22 AM, Resident #47 stated they get food from outside on Friday such as pizza. Resident #47 also stated that they were told that they cannot have outside food and family and friends do not bring them food and if they do they must have it in the dining room as they cannot bring it to the unit. During an interview on 07/31/2025 at 10:26 AM, Resident #96 stated they have been in the facility a few months and they were informed it was a kosher facility prior to coming. Resident #96 also stated they once ordered outside food but cannot afford to do this all the time as they would have to pay for it with their own money. On 07/31/2025 at 12:30 PM, the Registered Dietitian #1 was interviewed and stated resident are allowed outside food in a room downstairs in the Recreation room eating foods. Registered Dietitian #1 also stated the facility has kosher food and residents are not supposed to have food on the unit. During an interview on 07/31/2025 at 01:17 PM, the Food Service Administrator stated the patient population of the facility is predominantly African American and Spanish patients. The Food Service Administrator also stated the residents/resident representatives are made aware that the facility is a kosher facility. The Food Service Administrator further stated residents can have outside food, but they have to make a reservation for the food usually with the Recreation, or Nurse supervisor and the resident would have to eat in the Recreation room with the visitor. The Food Service Administrator stated residents are allowed to have outside food every Friday and can order Chinese or Italian food or bacon cheeseburgers. On 08/01/2025 at 12:32 PM, Resident Representative #1 for Resident #153 was interviewed and stated that they have tried to bring food from home for Resident #153 to consume and they have had to take it back home with them because they were not allowed to provide or bring outside food to the resident without prior approval from the facility. On 08/01/2025 at 12:33 PM, Resident #153 was re-interviewed and stated they were not allowed to bring outside food into the facility or consume outside food in the facility. Resident #153 also stated they were informed about the outside food, but this is different because at other facilities they were able to bring food into the building. Resident #153 further stated once they got takeout food on a family visit, and they were allowed to consume the food outside the building as they don't allow outside food in here. Resident #153 stated their fiancé cooks home cooked meals for them and (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they are craving outside food. Resident #153 further stated their family brought them food and they thought the family room area or cafeteria would be available, but they were told they could not eat in there because no food other than kosher food was allowed in the facility. On 8/4/2025 at 11:15AM, Resident #90 was interviewed, and stated the food here is horrible and they do not like the food, and they cannot get the foods they want. Resident #90 further stated they were told the facility was kosher 3 years ago, and they would like to be able to buy their own food, but they have to suffer along with the facility rule. On 08/04/2025 at 11:21 AM, Resident #133 stated their family brings food from home, and they have to eat it in the Recreation room. On 08/04/2025 at 11:24 AM, Resident #84 was interviewed and stated the food here is terrible and they do not let you bring in any food. Resident #84 also stated they were informed the facility is kosher, but they do not like the food, and they are thinking about transferring someplace else because they cannot eat the food. Resident #84 further stated they want food they can eat, regular food, and they are not asking for too much from the facility. During an interview on 08/04/2025 at 12:43 PM, Resident #83 stated they were informed the facility was kosher 4 weeks ago and they eat the food because they are starving. Resident #83 also stated their family, and friends bring them food, but they have to eat it downstairs. On 08/04/2025 at 12:53 PM, Resident #26 was interviewed and stated they were not informed that the facility was kosher, and they are not allowed to get food from outside. Resident #26 also stated their family can bring them food, but they have to make an appointment/reservations to bring them the food. Resident #26 further stated they cannot have cheese on their burgers, and everyone is asking for cheese for their burgers. During an interview on 08/04/2025 at 1:46 PM, Recreation Aide #1 stated they monitor the recreation room for visitors up to 2 times a week when visitors bring outside food for residents. Recreation Aide #1 also stated they make sure that the room is set up, the suction machine is plugged in and if a resident has a choking emergency that there is someone close by. Recreation Aide #1 further stated residents are offered take out on Fridays and they can order Chinese food, pizza or food from the deli. Recreation Aide #1 stated family are able to bring their own personal food, and it has to be eaten in the recreation room. During an interview on 08/04/2025 at 1:20 PM, the Rabbi stated the building is strictly kosher and most kosher facilities allow no outside food, as no outside food is allowed where kosher foods are served. The Rabbi also stated there are times family/visitors can make arrangement for outside food, and non-kosher foods are not allowed in the resident dining room or resident rooms. The Rabbi also stated that there is a Friday program where residents are offered to buy takeout food which is eaten in the recreation room, and this has been in place to offer residents the opportunity to have food supervised with Recreation and Social Work involved. Resident#12 admitted to the facility with diagnoses that include Coronary Artery Disease, Hypertension, End Stage Renal Disease and Hemiparesis. The admission Minimum Data Set, dated [DATE] documented Resident #12's cognition as intact, very important to have snacks available between meals and have family or close friend involved in (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discussions about their care. On 07/29/2025 at 12:20 PM, Resident #12 was interviewed and stated they do not like the food and that they are not allowed to bring in any food. Resident #12 also stated 3 weeks ago their child brought some Jello cups for them, which were confiscated by one of the Staff, and they were told it is a Kosher facility, and the Jello was not returned. Resident #12 further stated they are not Kosher, so they don't understand why they can't eat their own food. On 07/30/2025 at 11:00AM, during the Resident Council meeting, Resident #26 stated that stated that their food is not allowed in the facility. Resident #26 also stated they are not kosher, and are not allowed to bring in food, so they cannot have their food when they want. On 07/30/2025 at 11:00AM, during the Resident Council meeting, Resident #123 stated they can only order food on Fridays and that it is Chinese and Italian only. Resident #123 also stated they do not like the food here and only eat lunch and dinner when they can order the food on Fridays. On 08/01/2025 at 10:48 AM, Registered Nurse Supervisor#2 was interviewed and stated the residents are aware that food cannot be brought in from the outside, however, the residents can order food from any place that delivers, and it's facilitated by the Recreation department. Registered Nurse Supervisor#2 also stated food is ordered once a week by the Recreation department only, but if the family wants to bring in food, they must call the Social Worker ahead of time, and they will schedule a place on the 1st floor where it can be eaten in a designated area only. On 08/01/2025 at 10:54 AM, the Registered Dietician was interviewed and stated if residents want food from outside, the facility can arrange to have the food eaten in a specific area and the cannot eat it in their room. The Dietician also stated that the facility can order for them from a few restaurants, however the residents have to pay for the meal. On 08/01/2025 at 11:11 AM, the Activities Director who is also the Social Work Director was interviewed and stated the administration gives menus from which the residents can order food from on Fridays. The Activities Director also stated residents are not allowed to order from the outside, and no food can be delivered to the facility. The Activities Director further stated residents can have food brought in from outside, and if families bring food they recommend appointments first, because it can only be eaten on the 1st floor, and they must ensure there is adequate spacing in the dining area. The Activities Director stated that they can only order food for the residents on a Friday, because that is how the policy is written. On 08/04/25 at 4:00 PM, the Administrator was interviewed and stated that the facility is a Kosher facility, and no outside food is allowed in the facility, so they have instituted a program whereby once a week, residents can purchase food from outside, through the Recreation department. The Administrator also stated that this a supervised program, and the policy is part of the admission agreement and is posted in signs, and families and visitors can have the non-kosher food in the recreation and conference room, on the 1st floor. The Administrator further stated residents and families can make special requests if the residents are unable to leave their room whereby the facility will make sure that there is no food in the room besides the food brought in into the room, as to maintain the kosher rule no outside food is allowed on resident units. The Administrator stated they are not aware that there were any issues with the rule. 10 NYCRR 415.14(h)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1Based on observations, record review, and interviews conducted during the Recertification Survey the facility did not ensure that the residents were treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of resident quality of life. This was evident for 1 (Resident #90) of 3 residents reviewed for Activities of Daily Living out of an investigative sample of 34 residents. Specifically, Resident #90 with a history of refusing care was observed on multiple occasions having a strong urine odor on their person while in common areas and in their room shared with other residents.The findings are:The facility policy and procedure titled Quality of Life- Dignity dated last revised in August 2025, documented that the facility's policy is to ensure each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individually.Resident #90 had diagnoses which included Osteoarthritis, Diabetes, and Bipolar Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #90's cognition as moderately impaired with a Brief Interview for Mental Status score of 12. The Minimum Data Set 3.0 further documented Resident #90 required supervision for eating, dependent care for toileting and showers, and supervision with touch assistance for personal hygiene, and was frequently incontinent of bladder and always incontinent of bowel.On 07/28/2025 at 09:45 AM, a strong urine odor was observed outside Resident #90's room during Initial Pool observations. The room appeared clean, there was no debris observed on the floor and the bed was made with clean linens. Resident #90 was not in room at this time.On 07/29/2025 at 9:28 AM and 07/29/2025 at 9:44 AM, there was a strong urine odor detected in the hallway outside Resident #90's room. Resident #90 was observed sitting in a wheelchair in the room and stated that the strong odor of urine is coming from themself. Resident #90 also stated the housekeeper does clean their room, but the urine smell is still strong, especially on the mattress. Resident #90 further stated this does not make them feel good about themself, and they refuse showers because they are scared they will fall. On 07/30/2025 at 9:21 AM, Resident #90 observed sitting in wheelchair in their room completing word puzzles. A strong urine odor continued to emanate from the room and could be detected in the hallway outside of the room. Resident #90's clothing appeared clean and was changed from the previous day, their hair was well groomed, but the strong urine odor persisted. On 07/31/2025 at 12:14 PM, Resident #90 was observed sitting in the wheelchair at nurses' station and a strong urine odor was detected. Registered Nurse #1 who was sitting at the nurse's station stated they will change the cushion on Resident #90's wheelchair.On 08/04/2025 at 10:19 AM, Resident #90's room was observed with an uncovered mattress and persisting urine odor. A Nursing progress note dated 03/28/2025 at 01:38 pm, Resident #90 refused care on shift. A Nursing progress note dated 04/01/2025 at 02:14 pm documented Late entry 3/31/25 resident refused care at 2 pm. A Nursing progress note dated 6/5/2025 documented Resident #90 refused incontinence briefs change despite encouragement and educational counseling.A Nursing progress dated 07/11/2025 at 06:21 am documented Resident #90 refused all care and was verbally aggressive to Certified Nursing Assistant and urinated on floor.Multiple Psychiatric consults dated 01/06/2025 to 06/11/2025 contained no documented evidence Resident #90 behaviors regarding personal hygiene including and their environment addressed. Multiple Psychology progress notes dated 02/24/2025 to 07/26/2025 contained no documented evidence Resident #90 behaviors regarding personal hygiene including and their environment addressed. On 07/20/2025 at 02:23 PM, Certified Nursing Assistant #7 was interviewed and stated they are currently assigned to provide care for Resident #90 during July 2025. Certified Nursing Assistant #7 also stated Resident #90 requires extensive assistance of two persons for toileting, showers and personal hygiene. Certified Nursing Assistant #7 further stated Resident #90 refuses to change incontinence briefs on the night shift, will (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	often remove the incontinence brief and urinate on the floor and on the bed, and will only agree to change the incontinence brief when it is fully saturated with urine. Certified Nursing Assistant #7 stated they are aware of the strong urine odor which comes from Resident #90's bed because the bed usually has a plastic covering, but the covering is gone so the urine gets through to the mattress and soaks the bed causing the strong urine odor. The urine odor has also seeped into the cushion on the wheelchair. Certified Nursing Assistant #7 also stated they were not aware of the mattress or the cushion in the wheelchair being changed, and they report to the nurse daily that Resident #90 refuses care. On 07/31/2025 at 11:31 AM, Licensed Practical Nurse #2 was interviewed and stated Resident #90 is alert and oriented, and resistive to care. Licensed Practical Nurse #2 also stated Resident #90 refuses incontinence care and needs to be approaches multiple times and given a lot of encouragement from staff to change incontinent briefs and take showers. Licensed Practical Nurse #2 acknowledged there was a strong urine odor detected when approaching Resident #90's room, however the housekeeper cleans the room every day and the odor persists.On 07/31/2025 at 11:09 AM, Housekeeper #1 was interviewed and stated they were aware Resident #90 has behaviors of urinating on the floor and at times in the hallway. The Housekeeper #1 also stated when Resident #90 calls staff to be changed and staff do not respond right away they will get upset, remove the incontinence brief, urinate on the floor in the room, and take the incontinence to the nurse's station. and the urine will get all over the floor in the hallways. Housekeeper #1 stated they constantly clean Resident #90's room but there is no change in the smell of urine in the room. #328. On 07/31/2025 at 11:40 AM, Registered Nurse Supervisor #1 was interviewed and stated Resident #90 has known behaviors of refusing care, refusing to be changed, removing incontinence brief, and placing it on the floor. Registered Nurse Supervisor #1 also stated they have used multiple approaches including educating on personal hygiene and infection control, and reapproaching Resident #90. Registered Nurse Supervisor #1 further stated Resident #90 frequently refuses showers and fabricate stories at times, and the Interdisciplinary team has discussed Resident #90's behaviors. Registered Nurse Supervisor #1 stated every couple of months the mattress, floor mats and wheelchair cushions are changed, but they were unable to provide the date this last occurred. On 08/01/2025 at 8:59 AM, the Director of Nursing Services was interviewed and stated Resident #90 has a long-standing psychiatric history, is resistive to care, and refuses medications at times. The Director of Nursing Services also stated Resident #90 has poor hygiene overall, and the team meets with Resident #90 on a regular basis to discuss their personal hygiene and the odor in their room [ROOM NUMBER]. The Director of Nursing Services stated Resident #90 tries to be independent, but with their mental illness and impaired judgement, they need assistance. The Director of Nursing Services also stated they were not personally aware of the strong urine odor on Resident #90 person or in their room and was made aware of it on 7/30/2025 when informed by Registered Nurse Supervisor #1.On 08/01/2025 at 10:54 AM, the Director of Social Work was interviewed and stated Resident #90 has a history of refusing care, refusing showers, and removing their incontinence brief. The Director of Social Work also stated Resident #90 attends care planning meetings, and they have had one on one discussions with them for the past year regarding personal hygiene and Resident #90 will agree to improve and the next day go back to their behavior. The Director of Social Work further stated Resident #90's mattress is changed every 2- 3-week mattress and was last changed four days ago. On 08/04/2025 at 8:37 AM, the Housekeeping Director was interviewed and stated they were aware of the issues with the urine odor in Resident #90's room and the plan in place is to clean the room every day and as needed and to change the mattress as needed. The Housekeeping Director also stated despite cleaning the room daily the odor remains. The Housekeeping Director further stated they know it is not acceptable for the room to have a persisting urine odor, but they continue to clean daily. The Housekeeping Director added that Resident #90's mattress was last changed a few weeks ago but was unable to give a specific date when this occurred.10 NYCRR 415.5(a)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:2Number of residents cited:1 Based on record review and interview conducted during the Recertification survey, the facility did not ensure that, to the extent practicable, the resident participated in the development, review, and revision of the comprehensive care plan. This was evident for 1 (Resident #34) of 2 residents reviewed for Care Planning, out of 34 sampled residents. Specifically, Resident #34's care plan meeting had not been scheduled nor held since their admission on [DATE]. The findings are:The facility's policy titled Comprehensive Care Planning, effective 01/2014, last updated 01/25 documented that every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. The facility will assist residents to participate, e.g., helping residents, and families, legal surrogates or representatives understand the assessment and care planning process; when feasible, holding care planning meetings at the time of day when a resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's advocate to attend (e.g. family member, friend) if desired by a resident.Resident #34 was admitted to the facility with diagnoses that include Diabetes Mellitus, Pneumonia, and Malnutrition.The admission Minimum Data Set, dated [DATE] documented Resident #34 gad intact cognition, no behaviors, and participated in assessment and goal setting. On 07/29/2025 at 11:10 AM, Resident #34 was interviewed and stated they do not recall if they were invited or attended a care plan meeting. The Care Plan Meeting Schedule log dated 1/07/2025 to 7/31/2025 was reviewed and revealed Resident #34's care plan meeting had not been scheduled.There was no documented evidence in Resident #34's medical records that a care plan meeting was scheduled, and Resident #34 had been invited to attend a care plan meeting. On 08/04/2025 at 1:37 PM, the Social Worker Director was interviewed and stated residents are notified via sheets (invitation) and on the morning of the care plan meeting, the Registered Nurse Supervisor reminds the residents and asks if they want to attend or not. The Social Worker Director also stated the Minimum Data Set Coordinator schedules the care plan meeting. The schedule is on the calendar in the Electronic Medical Record, and the Social Worker Director will check to see if the care plan is scheduled. The Social Worker Director further stated based on the calendar that they were reviewing, there was no scheduled care plan meeting for Resident #34, and there should have been a care plan meeting for Resident #34. On 08/04/2025 at 1:58 PM, the Minimum Data Set Coordinator was interviewed and stated they are responsible for scheduling the care plan meeting. The Minimum Data Set Coordinator also stated when the Minimum Data Set is due, the care plan meeting is scheduled within the next 7 days, on either a Tuesday or a Thursday. The admission Minimum Data Set Coordinator further stated the Minimum Data Set assessment for Resident #34 was completed on 06/22/2025, and they usually do the scheduled care plan meetings on Excel, but this meeting probably did not go over to Electronic Medical Record, so the care plan meeting was missed.10 NYCRR 415.3(f)(1)(v)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the recertification survey from 07/28/2025 to 08/04/2025, the facility did not ensure a resident's right to receive services with reasonable accommodation of their needs and preferences. This was evident for 1 (Resident #151) of 31 total sampled residents. Specifically, Resident #31 was observed in their and they were not able to wash their hands in their bathroom sink without leaning forward and risk falling out of their wheelchair, their bathroom mirror was not on positioned appropriately for grooming, the cabinet in their room was at a height to allow them to access items in the cabinet, and the bottom drawers in their cabinet were difficult to access making it difficult for Resident #151 to access their clothing. The findings are:Resident #151 was admitted to the facility with diagnoses that included Anxiety disorder, Osteoarthritis of knee, and Pain. The Quarterly Minimum Data Set assessments dated 03/31/2025 and 07/09/2025 documented Resident #151 had intact cognition, required supervision or touching assistance with eating and participated in assessment and goal setting.The Quarterly Minimum Data Set assessment dated [DATE] and 07/09/2025 documented Resident #151 had intact cognition, required supervision or touching assistance with eating, dependent assistance with toilet transfer, partial/moderate assistance with upper and lower body dressing, and participated in assessment and goal setting. The assessments also documented Resident #151 used a wheelchair for mobility and was frequently incontinent of bowel and always continent of urine. The Annual Minimum Data Set assessment dated [DATE] in Section F Preferences for Customary Routines and Activities documented it was very important for Resident #151 to choose what clothes to wear and to take care of their personal belongings or things.On 08/01/2025 at 1:18 PM, Resident #151 was observed in the bathroom in their room. There was a tilted tilt mirror in the bathroom and Resident #151 was observed extending their body forward while seated in the wheelchair to be able to wash their hands properly as there was limited room at the sink to allow Resident #151 full access to the sink. On 08/04/2025 at 11:57AM, Resident #151's room was observed with the Director of Maintenance. Resident #151 was observed to be unable to reach the sink and had to lean forward in their wheelchair in order to reach the faucet handles, the toilet roll holder, and the bathroom cabinet. Upon observing this, the Director of Maintenance stated they needed to find Resident #151 another room to meet their needs, and they would have to see if they are any open rooms so their move can be coordinate with nursing. During an interview on 08/01/2025 at 1:20 PM, Resident #151 stated the mirror is not low enough for them to see their face when they are shaving, and they require assistance to get on and off the toilet in this room. Resident #151 also stated they cannot use the closet because of the way the door opens, and in order to take clothes out of their closet they have to bend forward in their wheelchair which makes them uncomfortable as they have fallen out of the wheelchair like this before. Resident #151 further stated that it is difficult to access the closet drawers for the same reason, so they hang their clothing outside of the closet. Resident #151 stated they cannot reach the bathroom dresser shelf when in the wheelchair and the toilet paper dispenser when seated on the toilet.During an interview on 08/04/2025 at 12:00 PM, the Director of Maintenance stated Resident#151's room was renovated and set up by an outside company. he Director of Maintenance also stated the company installed the fixtures in the bathroom and they do not check the installation. The Director of Maintenance further stated all rooms are designed the same and if a resident is in a wheelchair, they should be able to reach items in their room comfortably. 10 NYCRR 415.5(e)(1)

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	335737	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Lawrence Care Center, L L C	1410 Seagirt Blvd Far Rockaway, NY 11691

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Number of residents sampled:3Number of residents cited:1Based on interviews and record review conducted during the Recertification survey, the facility did not ensure a resident, or their designated representative was provided appropriate notification at the termination of Medicare Part A benefits. This was evident for 1 (Resident #27) of 3 residents reviewed for Beneficiary Notification out of 34 total sampled residents. Specifically, the Notice of Medicare Non-Coverage was not mailed out to Resident #27's designated representative on the same day telephone notification was made. The findings are: The facility policy titled Beneficiary Notice last revised 08/2025 documented that the facility must notify the resident and or legal representative of Medicaid/Medicare Coverage/Liability in such a manner to acknowledge and respect resident rights. The Notice of Medicare Non-coverage is given by the facility to all Medicare beneficiaries at least two days before the end of Medicare covered part A stay or when all of Part B therapies are ending. The Notice of Medicare Non-Coverage informs the beneficiary of the right to an expedited review by a quality improvement organization. Resident #27 was discharged from skilled rehabilitation services on 04/04/2025 and remained in the facility. The Notice of Medicare Non-coverage form documented a note written by the Minimum Data Set Coordinator on 04/02/2025 which stated that the Minimum Data Set Coordinator spoke with the sibling of Resident #27 and explained that rehabilitation service will end on 04/04/2025. Resident #27's sibling verbalized understanding of the contents of the notification. There was no documentation a copy of the Notice of Medicare Non-Coverage had been mailed to Resident #27's representative. On 08/04/2025 at 10:04 AM, the Minimum Data Set Coordinator was interviewed and stated that they had spoken to the sibling of Resident #27 who verbalized understanding of the contents of the Notice of Medicare Non-coverage, and they would not be appealing the decision. The Minimum Data Set Coordinator further stated that the procedure is that the Notice of Medicare Non-Coverage is to be mailed out 2 days before the ending of services, so that residents or their representatives have the time to appeal the decision. The Notice of Medicare Non-Coverage for Resident #27 should have been mailed out on the same day that telephone contact was made. The Minimum Data Set Coordinator further stated they were unable to mail out the Notice of Medicare Non-Ccoverage, so they had called one of the staff in the facility to mail it out on their behalf. It was confirmed by the Director of Social Work via email that it was mailed out via certified mail. The Minimum Data Set Coordinator further stated that the facility could not find the receipt to confirm it was sent out the same day telephone notification was made. On 08/04/2025 at 1:58 PM, the Director of Social Work was interviewed and stated that they occasionally help mail out the Notice of Medicare Non-coverage form if asked to do so by the Minimum Data Set Coordinator. The Director of Social Work stated that they mailed out the Notice of Medicare Non-coverage via certified mail to the family member of Resident #27 and had received a receipt but could not locate the receipt. The Director of Social Work further stated that they are aware it is important for the Notice of Medicare Non-Coverage to be sent out so that residents are aware they have the right to appeal. On 08/04/2025 at 1:52 PM, the Director of Nursing Services was interviewed and stated that Notice of Medicare Non-coverage should be mailed out the same day as telephone notification. The Director of Nursing services further stated that it is a matter of resident's rights, and they are unsure as to what happened in this scenario. 10 NYCRR 415.3 (g)(2)(ii)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 6Number of residents cited: 1Based on record review and staff interviews conducted during a Recertification and Complaint (759838) survey, the facility did not ensure that each resident is free from abuse, neglect, and corporal punishment of any type by anyone. This was evident for 1 (Resident #13) out 6 residents reviewed for Abuse. Specifically, Resident #13 was bit on their right arm by Certified Nursing Assistant #2 while being assisted with Activities of Daily Living on 03/23/2025. The findings include: The facility's policy and procedure titled Resident Abuse, Neglect, & Exploitation with effective date 3/2013 and last review date 1/2025 stated the facility is to ensure all residents are free from abuse, neglect, misappropriate of resident property, and exploitation. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy also stated the responsible person for Abuse Prohibition is the Director of Nursing. The policy further stated all prospective employees will be screened prior to employment to rule out any history of abuse, neglect or mistreatment or resident. All employees would be trained on abuse prevention policy. All incidents will be investigated. The facility will report all incident or violations where abuse, neglect, mistreatment of misappropriation of property suspected to New York State Department of Health according to protocol.Resident #13 had diagnoses including Hemiplegia, Vascular dementia, and Aphasia. The Annual Minimum Data Set assessment dated [DATE] documented Resident #13 had severely impaired cognition, had no behavior symptoms, no rejection of care and was dependent on staff for Activities of Daily Living. The Nursing note dated 3/23/2025 documented that Resident #13 stated they had been bitten by Certified Nursing Assistant #2. The Nursing note also documented Certified Nursing Assistant #2 admitted biting Resident #13 with a towel placed over Resident #13's right arm. The Nursing note further documented redness, and a bite mark was observed on Resident #13's right arm.The Employee Statement by Certified Nursing Assistant #2 documented they placed a towel over Resident #13's right arm and bit Resident #13's right arm through the towel.The Facility Investigation Report dated 3/28/2025 documented there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. The facility investigation report documented Resident #13 reported Certified Nursing Assistant #2 bit them. Certified Nursing Assistant #1 who was assigned to Resident #13 stated they asked Certified Nursing Assistant #2 for assistance as Resident #13 required 2-person assistance. Certified Nursing Assistant #1 witnessed a conversation between Resident #13 and Certified Nursing Assistant #2, in which Certified Nursing Assistant #2 told Resident #13 that if you bite me, I will bite you back. Certified Nursing Assistant #1 stated Resident #13 had tendencies to attempt to bite staff and could be resistive and combative during care at times. The facility investigation report documented Certified Nursing Assistant #1 observed Certified Nursing Assistant #2 place a towel on Resident #13's right arm as part of care. Certified Nursing Assistant #1 removed the towel after care and noticed redness and impressions on Resident #13's right arm. Certified Nursing Assistant #1 immediately reported the finding to the nurse on the unit. Certified Nursing Assistant #1 stated they did not witness Certified Nursing Assistant #2 biting Resident #13. The facility investigation report documented Certified Nursing Assistant #2 stated Resident #13 bit their right arm and that why they bit Resident #13 back. It also documented Certified Nursing Assistant #2 stated the placed their mouth over a towel on Resident #13's right arm and bit Resident #13. Licensed Practical Nurse #1 checked on Resident #13 and noticed redness on Resident #13's right arm after receiving report from Certified Nursing Assistant #1. Registered Nurse #1 assessed Resident #13 and interviewed all parties involved. The facility investigation report documented Certified Nursing Assistant #2 acknowledged biting Resident #13. It also documented 911 was called and police officers came and then left without arresting anyone. It further documented Certified Nursing Assistant #2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was suspended pending the outcome of the investigation.The Criminal History Record Check Termination Notice (Form 105) documented Certified Nursing Assistant #2 was terminated from the Criminal History Record Check Program on 3/25/2025. On 07/30/2025 at 10:05 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #13 tried to bite them during care and they told Resident #13 that they would bite back if Resident #13 did so. Certified Nursing Assistant #2 admitted they placed a piece of towel on Resident #13's right arm and put their mouth on the towel. Certified Nursing Assistant #2 stated they just played with Resident #13 and did not bite Resident #13. On 07/30/2025 at 9:29 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #13 had intact skin and no redness on skin before care. Certified Nursing Assistant #1 also stated only themself, Certified Nursing Assistant #2 and Resident #13 were in the room at the time. Certified Nursing Assistant #1 stated they observed Resident #13's right arm was covered by a piece of towel during care and the towel was not there before care. Certified Nursing Assistant #1 further stated they removed the towel after care and observed redness and teeth mark on Resident #13's right lower arm closed to elbow. Certified Nursing Assistant #1 stated they reported the finding immediately to the Licensed Practical Nurse #1. On 07/30/2025 at 9:36 AM, Licensed Practical Nurse #1 was interviewed and stated they went to see Resident #13 after receiving the report from Certified Nursing Assistant #1 about redness on Resident #13's right arm. Licensed Practical Nurse #1 also stated they observed Resident #13 had redness on the right arm close to elbow. Licensed Practical Nurse #1 further stated Resident #13 kept saying they were bitten. On 07/31/2025 at 8:56 AM, Registered Nurse #1 was interviewed and stated they assessed Resident #13 after receiving the report from Licensed Practical Nurse #1. Registered Nurse #1 also stated they found Resident #13 had redness in the shape of teeth bite on the right arm. Registered Nurse #1 further stated they had the two involved Certified Nursing Assistants, #1 and #2, stand in front of Resident #13 for Resident #13 to identify the abuser. Registered Nurse #1 also stated Resident #13 pointed at Certified Nursing Assistant #2 and stated they bit Resident #13. Registered Nurse #1 further stated Certified Nursing Assistant #2 was dismissed immediately, and they reported the incident to Director of Nursing immediately afterward. On 08/01/2025 at 8:49 AM, the Director of Nursing was interviewed and stated the facility started an investigation after receiving report of the incident. The staff involved were interviewed, and Certified Nursing Assistant #2 admitted they placed a towel on Resident #13's right arm and bit Resident #13. The Director of Nursing stated they determined that abuse did happen and terminated Certified Nursing Assistant #2. The Director of Nursing also stated all staff received training on abuse during orientation. 10 NYCRR 415.4(b)(1)(i)

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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** Number of residents sampled: 4Number of residents cited: 2 Based on record review and interview conducted during the Recertification and Complaint Survey (759831), the facility did not ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegations were made, to the State Survey Agency. This was evident for 2 (Resident #51 & Resident #104) of 4 resident reviewed for Abuse out of 34 total sampled residents. Specifically, the facility's incident report documented that on 11/11/2024 at 10:00 AM, Resident #51 hit Resident #104 with the leg rest of Resident #51's wheelchair, accusing them of stealing underwear. The Administrator was first made aware of the incident on 11/11/2024 at 10:45 AM, and the facility did not report the abuse allegation to the New York State Department of Health until 11/11/2025 at 02:52 PM.The findings are:The facility's policy titled Resident Abuse, Neglect, & Exploitation, effective 03/13, last reviewed 01/2025 stated the Administration/Director of Nursing is responsible to report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in seriously bodily injury, to the Administrator of the facility and to other officials in accordance with State law through established procedure.Resident #51 was admitted to the facility with diagnoses that include Non-Alzheimer's Dementia, Anxiety Disorder, and Schizophrenia.The Annual Minimum Data Set assessment dated [DATE] documented Resident #51 had severely impaired cognition, and had no behavioral symptoms directed towards others.Resident #104 was admitted to the facility with diagnoses that include End Stage Renal Disease and Depression.The Annual Minimum Data Set assessment dated [DATE] documented Resident #51 had short and long-term memory impairment and had no behavioral symptoms directed towards others.A Nurse's note dated 11/11/24 documented the New York City Police Department was notified of the altercation, 2 officers reported to facility from precinct and Resident #51 to be transferred to the hospital for psychiatric evaluation and departed the facility at 3:35 PM.The facility's report titled Occurrence Report, dated 11/11/24 at 10:00 AM, documented Resident #51 accused Resident #104 of stealing underwear. Resident #51 used the leg rest of the wheelchair to hit Resident #104 on their leg. Both residents were evaluated and denied any injuries. An emergency code was called, and the residents were separated. Both residents were evaluated and there were no visible injuries. Resident #51 was transferred to the hospital for evaluation. The Nursing Home Facility Incident Report documented that the incident occurred on Monday, 11/11/2024 at 10:00 AM, the Administrator was first made aware of the incident on Monday, 11/11/2024 at 10:45 AM, and the Director of Nursing reported the altercation to the New York State Department of Health on Monday 11/11/2024 at 14:52.On 08/04/2025 at 4:09 PM, the Administrator was interviewed and stated that they were made aware when the resident-to-resident interaction occurred. The Administrator also stated that the Director of Nursing that reported the altercation no longer works with the facility, but that they do not recall if the regulations state that all resident-to-resident interactions are to be reported within 2 hours. 10 NYCRR 415.4(b)(2)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification and Complaint (759832) survey conducted from 7/28/2025 to 8/02/2025, the facility did not ensure that they permitted each resident to remain in the facility, and did not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility. This was evident for 1 (Resident #151) out of 5 reviewed for Choices out of a sample of 34 residents. Specifically, Resident #151 was not permitted to return to the facility after they went out on pass and returned late and was instead transferred to the hospital. In addition, the facility failed to provide any documentation regarding Against Medical Advice status or a discharge notice provided to the resident prior to hospital transfer. The findings included:The facility policy Out on Pass with Responsible Party/Leave of Absence reviewed 7/10/2024 documented to enable residents to safely enjoy and spend quality time outside the confines of the facility, [NAME] Center to grant temporary leave form the facility (Out on Pass/Leave of Absence). This temporary leave is granted upon request by either resident or family/responsible party after assessment by the Interdisciplinary Team. A resident leaving the facility other than going for scheduled or approved medical purposes is considered as Out on Pass/Leave of Absence. Out on Pass maybe in the form of a day pass (before midnight) or overnight pass (after midnight). Residents who go Out on Pass with Responsible Party must return prior to midnight. Failure to return by midnight will be considered a voluntary Against Medical Advice and be discharged from our facility. If resident wishes to be readmitted resident must go to the Hospital and obtain a Patient Review Instrument for admission. The interdisciplinary team may also specify the number of hours a resident may go Out On Pass with Responsible Party based on their specific medical status, care needs, diet order and medication/treatment regimen. The facility policy and procedure Discharge Planning dated 01/2025 stated the facility will transfer or discharge resident only when such transfer or discharge is made in recognition of the resident's right to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the residents rights of other resident in the facility. The policy also stated the facility will transfer or discharge a resident only when the interdisciplinary team, in consultation with the resident or the resident designated representative determines that: transfer or discharge necessary for the residents welfare and the residents needs cannot be met after reasonable attempts at accommodation in the facility.Resident # 151 was admitted to the facility with diagnoses that included Anxiety disorder, Osteoarthritis of knee, and Pain. The Quarterly Minimum Data Set assessment dated [DATE] and 07/09/2025 documented Resident #151 had intact cognition, required supervision or touching assistance with eating and participated in assessment and goal setting.The Annual Minimum Data Set assessment dated [DATE] documented in Section F Preferences for Customary Routines and Activities that it was very important to do their favorite activities and things with groups of people. The Physicians order initiated on 6/3/2022, last renewed on 7/16/2025 documented Resident #151 can go out on pass with a responsible party. The Nursing Progress notes dated 11/1/2024 documented at 10:17 PM, Resident went out of pass during 3 PM -11 PM shift for daughter's wedding. Resident did not return as of 10:15 PM, 3 PM-11 PM shift endorse to 11 PM-7 PM shift to follow up on return, The Nursing progress note dated 11/1/2024 at 11:56 PM, documented at 11:49 PM, Resident did not return from out on pass, call placed to emergency contact #4 that picked resident up message left with reminder that resident must be back in the facility prior to 12 AM. The Nursing progress note dated 11/2/2024 at 12:09 AM, documented 11:56 PM another call placed to emergency contact #4 was unanswered. Reminder message left that resident must be back prior to 12 AM for acceptance back to the facility. Attempt made to call emergency contact #1 was (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsuccessful, Social Worker informed. The Nursing progress note written by Registered Nurse #5 on 11/2/2024 at 1:09 AM documented at 12:35AM call received from front desk the resident arrives outside the facility and wants to speak with writer. Resident noted sitting in wheelchair in entry area alone without responsible party. When asked for responsible party that he returned with the resident stated she is gone, she is incapacitated car noted reversing form driveway. Resident #151 was reeducated that Out On Pass protocol is that return must be done prior to 12 AM and if not, is considered as a voluntary Against Medical Advice so the responsible returning party would need to resume responsibility. Resident #151 was notably upset, the former Director of Nursing and Director Social Worker were notified. The Director of Social Work stated that resident has to return with party, or if left alone 911 has to be called. The Director Social Worker is able to speak with resident. Documented at 12:43 - 911 called to pick resident up and at 12:48 PM- 911 arrives resident picked up and taken to hospital. There was no documented evidence Resident #151 was permitted to return to the facility and appropriately assessed for any ill effects from being away from the facility longer than expected when they returned later than agreed upon after a therapeutic leave. In addition, there was no evidence in the medical record that Resident #151 was evaluated by their Physician, and the information for the basis of the transfer was documented. The Nursing progress note dated 11/4/2024 at 2:41 PM documented Resident #151 was readmitted at 1:47 PM from the hospital in stable condition, alert and oriented, able to make needs known. Resident went Out on Pass and signed Against Medical Advice to hospital. Resident refused readmission assessment. Medical Doctor aware of readmission and medication reconciled. Monitoring continues.The Medical progress note dated 11/5/2024 at 6:11 PM, documented Resident #151 was readmitted on [DATE] after hospitalized on [DATE] as was denied entry to skilled nursing facility due to late arrival and missing reentry curfew and required reevaluation. After medical optimization and hemodynamically stable, Resident discharged from the hospital and has been readmitted to our facility. Hospital records reviewed, medication reconciliation and no altered mental status. There was no documented evidence provided regarding the Out on Pass notice provided to Resident #151 on 11/02/2024 or the Against Medical Advice form that Resident #151 signed prior to being transferred to the hospital after returning 30 minutes late from pass. During an interview on 07/28/2025 at 11:51 AM, Resident #151 stated they got back after midnight, and they were locked out of the building, and they were sent to hospital for the weekend due to violating curfew. Resident #151 also stated that there was no set return time documented on the paperwork. Resident #151 further stated that in November 2024 it was cold outside, and they were taken to the hospital. Resident #151 stated they did not want to go to the hospital, but they were told they had to go.During an interview on 7/31/2025 at 3:17 PM, Emergency Contact #1 for Resident #151 stated they were not called and notified Resident #151 was sent to the hospital. Emergency Contact #1 also stated they ordered an Uber to take Resident #151 back to the facility and they arrived at the facility at 12:30 AM. During an interview on 08/01/2025 at 10:30 AM, the Director of Social Work stated Resident #151 was late returning from pass. The Director of Social Work also stated when residents return from pass after midnight they are sent to the hospital and have to go to the hospital and get a Patient Review Instrument completed in order to be readmitted to the facility. During an interview on 08/01/2025 at 11:01 AM, Registered Nurse #5 stated when a resident goes out on pass an Out on Pass form is completed which has the contact information for the designated person and residents have to be back in the facility before midnight. Registered Nurse #5 also stated the Nursing Supervisor, or unit nurse will contact the resident or designated representative 1 hour before 12 AM to let them know they have to be back before midnight. Registered Nurse #5 further stated Resident #151 attended their child's wedding and needed to be back before 12 AM, so they contacted Resident #151 and their designated representative, and no one answered the call. They also tried unsuccessfully to reach all the other emergency contacts and informed the Social worker and the Director of Nursing when they were unable to do so. Registered Nurse #5 stated they were notified by the facility receptionist by phone that Resident #151 was downstairs on 11/02/2024 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and they met Resident #151 at the doors and Resident #151 explained that they did not hear the phone. Registered Nurse #5 stated the Social Worker and Director of Nursing were contacted by phone and informed Resident #151 they had to go to the hospital, and Resident #151 was sent to the hospital. During an interview on 08/01/2025 at 11:22 AM, the Director of Nursing there may be reasons for a resident's late arrival back to the facility, such as traffic accident and patients are educated individually. The Director of Nursing also stated when a resident arrives after midnight circumstance of late arrival is reviewed on a case by case basis, and sometimes if a resident arrives after midnight they are transferred to hospital as Against Medical Advice. During an interview on 8/4/2025 at 2:11 PM, the Administrator stated when Resident came back late from pass the Director of Nursing directed the nursing supervisor to send the resident to the hospital.10 NYCRR 415.3(i)(1)(iii)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 3Number of residents cited: 1 Based on record review and interviews conducted during the Recertification survey from 07/28/2025 to 08/04/2025, the facility did not ensure Comprehensive Care Plans were reviewed based on changing goals, preferences and needs of the resident and in response to current interventions. This was evident for 1 (Resident #90) out of 3 residents investigated for Activities of Daily Living out of a total investigative sample of 34 residents. Specifically, Resident #90 was observed on multiple occasions with strong odor of urine on their person and in their room, and there was no evidence that the Comprehensive Care Plan was revised to include interventions to address Resident #90's ongoing behavior of refusal of care. The findings are:The facility policy and procedure policy titled Comprehensive Care Planning last reviewed 01/2025 stated the Comprehensive Care Plan must describe the following including the services that are to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being. The facility policy and procedure policy titled Activities of Daily Living Protocol stated the plan of care will be reviewed by all responsible disciplines for consistency in delivery of care as well as ensuring that the plan of care accurately reflects the resident's current status. Resident #90 had diagnoses which included Osteoarthritis, Diabetes, and Bipolar Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #90's cognition as moderately impaired with a Brief Interview for Mental Status score of 12. The Minimum Data Set 3.0 further documented Resident #90 required supervision for eating, dependent care for toileting and showers, and supervision with touch assistance for personal hygiene, and was frequently incontinent of bladder and always incontinent of bowel.On 07/28/2025 at 09:45 AM, a strong urine odor was observed outside Resident #90's room during Initial Pool observations. The room appeared clean, there was no debris observed on the floor and the bed was made with clean linens. Resident #90 was not in room at this time.On 07/29/2025 from 9:28 AM to 9:44 AM, there was a strong urine odor detected in the hallway outside Resident #90's room. Resident #90 was observed sitting in a wheelchair in the room and stated that the strong odor of urine is coming from themself. Resident #90 also stated the housekeeper does clean their room, but the urine smell is still strong, especially on the mattress. Resident #90 further stated this does not make them feel good about themself, and they refuse showers because they are scared they will fall. On 07/30/2025 at 9:21 AM, Resident #90 observed sitting in wheelchair in their room completing word puzzles. A strong urine odor continued to emanate from the room and could be detected in the hallway outside of the room. Resident #90's clothing appeared clean and was changed from the previous day, their hair was well groomed, but the strong urine odor persisted. On 07/31/2025 at 12:14 PM, Resident #90 observed sitting in the wheelchair at nurses' station and a strong urine odor was detected. Registered Nurse #1 who sitting at the nurse's station stated they will change the cushion on Resident #90's wheelchair.The Comprehensive Care Plan titled Activity of daily Living Tasks functional decline; status post hospitalization requires extensive assistance with Activity of Daily Living dated created 8/21/2020 and last evaluation note 6/20/2025, did not contain personalized interventions to address Resident #90's ongoing strong urine odor in their room and on their person, and instead documented the level of assistance Resident #90 required for Activities of Daily Living Care. The Comprehensive Care Plan titled Behavior Symptoms: Resists Care/ Noncompliance Psychiatric disorder, Noncompliance with daily care needs, Noncompliance with medication, Noncompliance with ambulation and transfer status removes clothes, incontinent brief, throws food all over on the floor. Stays naked in bed. Refuses medications at time. Urinates on floor and bed, refuses to allow room to be cleaned at times, refuses showers created 8/27/2020 and last evaluation note dated 6/11/2025 did not contain personalized interventions to address Resident #90's ongoing strong urine odor in their room and on their person. A (continued on next page)

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	335737	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Lawrence Care Center, L L C	1410 Seagirt Blvd Far Rockaway, NY 11691

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress note dated 03/28/2025 at 01:38 pm, Resident #90 refused care on shiftA Nursing progress note dated 04/01/2025 at 02:14 pm documented Late entry 3/31/25 resident refused care at 2 pm. A Nursing progress note dated 6/5/2025 documented Resident #90 refused incontinence briefs change despite encouragement and educational counseling.On 08/04/2025 at 1:08 PM, Registered Nurse Supervisor #1 stated they are responsible for initiating and updating care plans. Registered Nurse Supervisor #1 also stated they try to encourage Resident #90 in different ways and tried to be creative on how to have Resident #90 comply with care. Registered Nurse Supervisor #1 further stated the care plans interventions for Activities of Daily comes from the Certified Nursing Accountability record. Registered Nurse Supervisor #1 stated they can add interventions to address the resident's education on personal hygiene, risk for infection, and the importance of keeping the environment clean. Registered Nurse Supervisor #1 also stated they did have a note on 6/28/2024 when they educated Resident #90 on compliance with personal hygiene to help prevent infection. Registered Nurse Supervisor #1 stated they could personalize Resident #90's care plan to include all the interventions the team is doing to have Resident #90 comply with care, and in keeping the environment clean On 08/04/2025 at 4:09 PM, The Director of Nursing was interviewed and stated care plans should be person-centered, and staff should assess and look at the idiosyncrasies of each resident, and care plan based on their individual needs. The Director of Nursing also stated this is done for all residents, and this is a huge initiative, to personalize all care plans. 10 NYCRR 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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1Based on observation, record review, and interviews during the Recertification survey, the facility did not ensure that a therapeutic diet was provided when there is a nutritional problem, and the health care provider orders a therapeutic diet. This was evident for 1 (Resident #83) of 5 residents reviewed for Nutrition out of a total of 34 sampled residents. Specifically, Resident #83, who had a Physician's order for pureed food and honey thickened liquid, was observed eating leftover chopped beans and drinking apple juice from the tray of another resident prescribed a chopped diet and thin liquids. The findings are: The facility's policy titled Aspiration Precautions last revised 08/2025 stated the facility ensures that all residents are assessed for risk factors for aspiration, implement, educate and monitor resident and Interdisciplinary team members on interventions and precautions to prevent the occurrence of aspiration. Constant supervision with intake is needed. The facility's policy titled Dysphagia Clinical Protocol last revised 08/2025 stated the physician will order an altered consistency diet when it is clinically appropriate to manage significant risks of aspiration in individuals for whom other alternatives are unavailable, not feasible, or have not worked. Resident #83 had diagnoses which included Malnutrition, Gastroesophageal Reflux Disease, and Altered Mental Status. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #83 had impaired cognition, required supervision assistance for eating, and is on a mechanically altered diet. A Nursing progress note dated 05/24/2025 documented Resident #83 was noted trying to take food from another resident's left over and must be monitored closely at mealtime. A Social work progress note dated 05/27/2025 documented that Resident #83 has a behavior of taking food off other residents' trays. Interdisciplinary team to monitor resident and provide support to resident. A Nursing progress note dated 06/04/2025 documented Resident #83 was observed taking non-pureed food items from another resident. Resident #83 was redirected by staff and was reinforced that sharing food is not permitted. Resident was informed of the risk of aspiration if they are not compliant with diet. Resident #83 was placed to dine at separate table to minimize episode of the mentioned behavior. Staff will continue to monitor resident closely and offer redirection. The sixth-floor dining room seating chart displayed that Resident #83 was to be seated with two other residents who are also prescribed a pureed diet. A Care Plan with focus Choking/Aspiration was initiated on 3/25/2019 and last updated on 07/27/2025 with facility interventions that included to provide diet as ordered: regular diet, puree consistency, honey thickened liquids and supervise/assist resident to eat slowly. A Care Pan with focus Nutrition/Hydration Status as evidenced by Resident #83 noted with behaviors including attempting to steal food from resident's tray was initiated on 03/22/2019 and last revised on 05/12/2025. The facility interventions included to monitor for signs of choking/aspiration. A Care Plan with focus Activities of Daily living all task was initiated on 03/22/2019 with facility interventions that included supervision assistance for eating, one-person physical assist for support and pureed food with honey thickened liquid/choking. Resident on Aspiration precautions. A note included to seat resident as per seating chart and supervise during meals. A Physician's Order renewed on 07/16/2025 documented the following dietary orders: regular with pureed consistency and honey thickened liquids. May have bread, soft sandwiches, and cake. A Speech Therapy Quarterly assessment dated [DATE] documented that Resident #83 is to be on pureed solids and honey liquids with instructions to maintain aspiration precautions. On 07/28/2025 at 12:21 PM, Resident #83 was observed moving the left-over tray of Resident #39 closer to them. Resident #39 was not present at the table as they had finished eating and left the table earlier. Resident #39's meal ticket documented that Resident #39 was on a chopped diet with chopped hamburger and beans. The State Surveyor asked Resident #83 if this was their tray to which they responded yes and proceeded to place a couple of pieces of the chopped beans into their mouth and take a sip of apple juice from the left-over tray of Resident #39. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #8 and Licensed Practical Nurse #3 were seated at the table next to Resident #83 feeding other residents. Certified Nursing Assistant #8 then notified Licensed Practical Nurse #3 and informed Resident #83 that it was not their tray and moved the tray back to where it was originally on the same table. The tray was not removed from the table and contained a few pieces of beans and an unopened coffee creamer which was still accessible to Resident #83. On 07/30/2025 at 2:41 PM, Licensed Practical Nurse #3 was interviewed and stated Resident #83 is on a pureed diet with thickened liquids. Normally Resident #83 is seated with other residents who are all on pureed diets. Licensed Practical Nurse #3 also stated 07/28/2025 was the first time Resident #83 was seated with Resident #39, and Resident #83 has attempted in the past to take food from the trays of other residents. Licensed Practical Nurse #3 further stated that it was an unfortunate situation as they were feeding another resident and had their back turned to Resident #83, and it was brought to their attention by Certified Nursing Assistant #8. By the time the staff realized, Resident #83 had already eaten a few pieces of Resident #39's leftover food. Licensed Practical Nurse #3 stated while Resident #83 is alert, they also have impaired cognition, and staff must remind them often to refrain from eating food off the tray of other residents. Licensed Practical Nurse #3 also stated Resident #83 must be supervised closely to make sure they are safe when eating and do not harm themselves as they may take food off other residents and also has a habit of slipping away. Licensed Practical Nurse #3 further stated Resident #83 is at risk for aspiration and choking if they consume the food of other residents, in addition, to the spread of germs and infections. On 08/01/2025 at 10:11 AM, the Registered Dietician was interviewed and stated Resident #83 is on a regular diet with puree consistency and honey thickened liquids. As of January 30, 2024, Resident #83 is on aspiration precautions and cannot handle any other consistency of foods aside from pureed. If Resident #83 does consume other consistencies of food, they have a possibility of choking. The Registered Dietician also stated to limit episodes, it is important to ensure there are staff to monitor Resident #83 consistently, as Resident #83 does have altered mental status and behavioral issues and is unable to make decision on their own and can-do things that can be unsafe. It is important there is staff to monitor them. On 08/01/2025 at 2:40 PM, Certified Nursing Assistant #8 was interviewed and stated they witnessed Resident #83 taking the tray of another resident at which time they informed the Licensed Practical Nurse #3. Certified Nursing Assistant #8 further stated that to their knowledge, Resident #83 did not have a history of taking food of other residents and there are seating charts for all residents that are seated in the dining room. On 08/01/2025 at 2:44 PM, Registered Nurse Supervisor #3 was interviewed and stated they were made aware of the incident by Certified Nurse Assistant #8 and Licensed Practical Nurse #3 when they came into the dining room. Registered Nurse Supervisor #3 stated Resident #83 is currently on a puree consistency diet, and it can be an issue if Resident #83 consumes the food of other residents as it is an aspiration risk, choking risk, allergy issue, and infection control issue. Registered Nurse Supervisor #83 further stated while there are progress notes documenting Resident #83 has taken food off other residents, this was the first time the behavior was reported to them. On 08/04/2025 at 10:53 AM, Speech Therapist #1 was interviewed and stated they do screenings quarterly and evaluated Resident #83 on May 8th, 2025, with recommendations to continue with the current diet. Speech Therapist #1 also stated Resident #83 has a history of dysphagia, difficulty chewing and swallowing food safely, and also has a history of taking foods where it is accessible. Speech Therapist #1 further stated there is a risk of aspiration if Resident #83 consumes the food off other resident's trays because Resident #83 is on a pureed diet with honey thickened liquids which is the safest for them at this time. On 08/04/2025 at 1:52 PM, the Director of Nursing Services was interviewed and stated that there are residents that do attempt to take food off other residents, particularly, if they are confused and on an altered diet. The Director of Nursing Services also stated if a resident on a specific diet consumes food of other resident, it is a risk of aspiration, cross contamination and risk for safety. Staff are responsible to supervise residents and report appropriately. The Director of Nursing Services further stated that residents should be monitored closely. 10 NYCRR 415.12(i)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This was observed in the 1st Floor visitor bathroom Specifically, from 07/28/2025, to 07/30/2025 the visitor and staff female bathroom located on 1st floor was observed with large, rusted area on the bottom of the bathroom barrier, a missing tile creating a hole at back of the toilet, the light fixture was uncovered, and there was mis-matched paint on the walls.The findings include but are not limited to:The facility's policy and procedure titled Maintenance/Housekeeping dated last revised 12/2024 documented the during regular inspection staff will survey, check and inspect all common areas, mechanical spaces and resident rooms. The policy further documented the resident rooms are inspected for cleanliness, odors and general good housekeeping. On 07/29/2025 at 11:18 AM, and 07/30/2025 at 09:00 AM, the visitor female bathroom was observed with a large, rusted area noted on the bottom on the left side of the toilet barrier. There was a missing tile with an open area to the back of the toilet on the left side. In addition, the light fixture was uncovered and there was mis-matched paint on the walls.On 08/04/2025 at 11:30 AM, the Maintenance Director was interviewed and stated they are responsible for making rounds and fixing anything that needs to be fixed around the building. The Maintenance Director also stated the staff reports any concerns to be fixed and they will respond and send one of the workers to fix the areas. The Maintenance Director further stated they were not aware of the large, rusted area and the missing tile in the female restroom on the first floor and this was not reported to the Maintenance Director. On 08/04/2025 at 4:09 PM the Administrator was interviewed and stated they were not made aware of any environmental issues and the Maintenance Director does not report small issues to Administrator. 10 NYCRR 415.29

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews conducted during the Recertification survey, the facility did not ensure that that the notice of the availability of the most recent New York State Department of Health survey report and plan of correction, was posted in areas that are prominent and readily accessible to the public. Specifically, there were no prominent postings of notices of availability throughout the facility. In addition, members of the Resident Council were unable to identify locations where signs or postings documented the availability and location of the survey results.The findings are:The facility's policy titled Posting of Survey Findings, Effective Date: 3/2013, last reviewed 8/2025, documented that a copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state approved plans of correction of noted deficiencies, is maintained in a 3-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room. The policy also documented copies of previous survey reports and state approved plans of correction are available upon request to the public, residents or their legal representatives (sponsors), designated ombudsman representative, and staff members. Requests for past survey results should be made in writing, signed and dated, and presented to the Administrator, or his/her designee, during normal business hours.On 07/28/2025 at 10:00AM, the Survey results binder was observed in the lobby, on the wall, opposite the receptionist's desk. On 07/30/2025 at 11:30 AM, the Survey results binder was observed in the lobby, on the wall, opposite the receptionist's desk. The binder contained only the results of the last Recertification survey, 07/14/23. There were no complaint surveys in the binder.On 07/30/2025 at 11:00 AM, a Resident Council meeting was held. Seven Residents were in attendance and Resident #26 and Resident #123 stated they had not seen a sign or posting indicating the location of the New York State Department of Health survey results.From 07/28/2025 to 08/01/2025 multiple observations were made on the units and revealed that there were no notices of availability and location of the survey results posted throughout the facility lobby. On 08/01/2025 at 11:21 AM, the Administrative Assistant was interviewed and stated they are responsible for posting the survey results and the binder is located in the lobby. The Administrative Assistant also stated that they were not aware that that the notice of the location of the survey results is supposed to be on all the units and that the survey binder should also contain all recertification and complaint surveys for the past 3 years. The Administrative Assistant further stated they just thought they had to update the binder. On 08/04/25 at 4:00 PM, the Administrator was interviewed and stated that they were aware that the survey binder should include all surveys for the past 3 years and that it was an oversight that the survey binder was not updated. The Administrator also stated that they were not aware that the notices for location of the survey binder should have been posted on the units and on the 1st floor. 10 NYCRR 415.3 (d)(1)(v)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 2Based on record review and interview conducted during the Recertification survey, the facility did not ensure the Minimum Data Set 3.0 assessments accurately reflected resident's status. This was evident for 1 (Resident #89) of 1 resident reviewed for Dental and 1 (Resident #34) of 4 residents reviewed for Accidents out of 34 total sampled residents. Specifically, 1). The Minimum Data Set Assessment did not reflect Resident #89's dental status as edentulous, and 2). The admission Minimum Data Set assessment did not reflect Resident #34 had a fall prior to admission. The findings are: The undated facility policy and procedure titled Minimum Data Set (MDS 3.0) stated the Minimum Data Set (MDS 3.0) is a federal mandated specific instrument to be used for conduction of a comprehensive assessment of all nursing home residents, initially and periodically. The policy further stated the purpose is to conduct consistent and periodic review of residents consistent with accepted standards. 1.Resident #89 had diagnoses which included Hypertension, Seizures, and Dementia. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #89 was cognitively intact. Section L 0200 Dental of the admission Minimum Data Set documented none of the above present indicating Resident #89 had no dental issues. On 07/29/2025 at 11:59 AM, Resident #89 was observed lying in bed. Resident #89 stated they have no teeth and would like to have dentures. The Dental consult for Resident #89 dated 2/18/2025 documented on evaluation Resident #89 is completely edentulous. No abnormalities noted. The Dental consult dated 5/23/2025 for Resident #89 documented on oral exam patient is completely edentulous. No abnormalities noted. The Dental Care Plan for Resident #89 created 2/10/2025 and last reviewed 5/14/2025 documented oral dental status as edentulous. The admission Minimum Data Set 3.0 assessment did not accurately document Resident #89's dental status as edentulous. On 08/04/2025 at 10:25 AM, Resident #89 was re-interviewed and stated they were admitted to the facility with no teeth. On 08/04/2025 at 10:04 AM, the Minimum Data Set Coordinator was interviewed via telephone and stated they were responsible for completing the Minimum Data set 3.0 assessments for the facility. The Minimum Data Set Coordinator stated when completing the Minimum Data Set, they will open the resident's medical record, and review nurse's notes, medical notes, any uploaded documents like consults, the Medication Administration Record, Treatment Administration Record and speaks to staff. The Minimum Data Set Coordinator also stated they will speak to whoever is able to give (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	information for the residents. The Minimum Data Set Coordinator further stated they completed Section L, Dental, in the Minimum Data Set assessment and Resident #89 does not have any dental problems. The Minimum Data Set Coordinator stated if Resident #89's Dental consult stated they are edentulous, this should be coded on the Minimum Data Set assessment. The Minimum Data Coordinator stated they only work remotely and had not physically seen Resident #89 as they only review the chart when completing the assessment. On 08/04/2025 at 10:41 AM, the Minimum Data Set Consultant was interviewed via telephone and stated they are responsible for overseeing the Minimum Data Set Department ensuring that the schedules are followed for completing and submitting Minimum Data Sets 3.0 timely. The Minimum Data Set Consultant also stated the person who signs off in section Z100 is the person responsible for the accuracy of the Minimum Data Set, and by signing Section Z100 the person is attesting that the Minimum Data Set is correct. The Minimum Data Set Consultant added they are not responsible for the accuracy of the Minimum Data Set assessment. 2. Resident #34 was admitted to the facility with diagnoses that include Diabetes Mellitus, Pneumonia, and Malnutrition. The admission Minimum Data Set assessment dated [DATE] documented Resident #34 had intact cognition, no behaviors, no impairments, needed supervision for eating, moderate assistance for bed mobility, and maximal assistance for chair and toilet transfer. The Minimum Data Set assessment also documented Resident #34 did not have a fall any time in the last 2-6 months prior to admission/entry or reentry. The Comprehensive Care Plan titled Cognition, created on 6/18/2025 included a goal of resident will maintain current level of cognitive status. Interventions include to monitor for changes or decline in cognitive status. The Inpatient Discharge summary dated [DATE] documented Resident #34 was admitted to the hospital on [DATE], presented for ground level fall with level of consciousness. On 08/04/2025 at 10:16 AM, the Minimum Data Set Coordinator was interviewed and stated that they are responsible for entering the information for the Minimum Data Set, dated [DATE], Section J1700, B, which indicated if there were any falls in the last 2-6 months, prior to entry. The Minimum Data Set Coordinator also stated they reviewed Resident #34's medical record, including the hospital discharge summary, however they guess that they missed Resident #34 had a fall, as it was documented on the summary, and it should have been coded as such on the Minimum Data Set assessment. On 08/04/2025 at 4:09 PM, the Director of Nursing was interviewed and stated that they oversee the Minimum Data Set Coordinator and there has been nothing too egregious prior to this omission with Resident #34. The Director of Nursing also stated the facility does audits of assessments and checks for accuracy. The Director of Nursing further stated the staff who fills out the specific sections in the Minimum Data Set are responsible for the accuracy of those sections. 10 NYCRR 415.11 (b)