STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335750	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fishkill Center for Rehabilitation and Nursing	22 Robert R. Kasin Way Beacon, NY 12508

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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 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. 45478 Based on observation and interview conducted during the recertification survey, the facility did not ensure that resident's dignity was maintained. Specifically,1) residents were being served milk and water in plastic storage cups with lids on 4 of 4 units (South 1, North 1, South 2 and North 2) and 2) and Certified Nurse Assistant #7 referred to Resident #26 as a feeder. In addition, a Resident progress note in the facility Electronic Medical Record also referred to Resident #26 as a feeder. The findings are: 1) Observations were made throughout survey from 2/10/25 to 2/14/25 on South 1, North 1, South 2 and North 2 units of residents being served milk and water out of plastic storage cups with lids. Observations were made on North 2 Unit on 2/10/25 at 12:24 PM and 2/11/25 at 12:21 PM, of residents being served milk and water out of plastic storage cups with lids. On 2/12/25 at 10:28 AM during the Resident Council Meeting 10 of 10 residents stated they were served milk and water in plastic storage cups and they preferred to use a hard plastic drinking cup. During interview on 02/12/25 at 2:24 PM the Food Service Director stated they pre-pour water and Lactaid milk to provide 4 oz of water or milk. The Lactaid milk only came in 8 oz containers and a portion size was 4 oz, so they poured the Lactaid milk into the storage cups with lids because the drinks needed to be covered. The Food Service Director stated they had hard plastic drinking cups in the main dining room and on the units in the small dining areas. The Food Service Director stated they stored the hard plastic drinking cups in the main dining room and on the units. The Food Service Director stated they were not aware that resident's should not use the storage cups with lids for drinking. During observation on 2/12/25 at 3:52 PM, 26 hard plastic drinking cups/non-disposable cups were on the tables in the main dining room. The South 1, North 1, South 2 and North 2 units only had disposable plastic storage cups with lids. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 2/12/25 at 3:52 PM the Food Service Director stated the facility did not have hard plastic drinking cups on the units only had 31 hard plastic drinking cups in the main dining room. The Food Service Director further stated they now only had 26 hard plastic cups in the building. The Food Service Director stated if they left the hard plastic drinking cups on the units they would walk, or be taken. During interview on 2/13/25 at 9:24 AM the Food Service Director stated they last ordered hard plastic drinking cups a couple weeks ago but they had not been delivered. The Food Service Director stated they were not sure why they did not receive the hard plastic drinking cups. During interview on 2/13/25 at 12:06 PM, the Director of Rehabilitation stated they had seen the disposable storage cups being used by residents for drinking and had discussed this with the Director of Nursing. The Director of Rehabilitation stated residents should use hard plastic drinking cups especially since residents have a difficult time holding plastic storage cups. 50766 2) Resident #26 was admitted with diagnoses including Alzheimer's, Polyosteoarthritis, and Psychotic Disorder with Delusions. The Resident Care Plan (dated 1/14/2019) documented provide encouragement and set-up help. The Quarterly Minimum Date Set (a resident assessment tool), dated 12/10/24, documented Resident #26 had severe cognitive impairment and was dependent with eating. The Progress Note dated 12/17/24 documented resident is a feeder. During an observation and interview on 02/11/25 at 08:54 AM, Certified Nurse Assistant #7 presented to Resident #26's room with a breakfast tray. When asked by the surveyor regarding Resident #26's meal intake, Certified Nurse Assistant #7 referred to Resident #26 as a feeder. During an interview on 2/12/25 at 11:24 AM Certified Nurse Assistant #7, stated they referred to Resident #26 as a feeder on 02/11/25 at 08:54 AM during interview with the surveyor because the resident required assistance with meals. They stated they realized using the word feeder was inappropriate after the interview and knew they had used the wrong terminology for a resident who required assistance with meals. Certified Nurse Assistant #7 stated they had received in-service regarding dignity within the past year. During an interview on 02/13/25 at 10:10 AM the Director of Nursing stated Certified Nurse Assistants received dignity in-services annually. They stated that the use of the word of feeder is not an acceptable terminology in the facility and should not be used verbally or in resident clinical documentation. 10 NYCRR 415.5 (d) (1)(i)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45478 Based on observation and interview conducted during the recertification survey, the facility did not ensure that a clean, comfortable, and homelike environment was provided. Specifically, North 2 unit rooms (S3, X1, X3, X6, V1, V3) had broken tiles, cracked walls, hanging curtains or damaged windows, the shower room had a damaged drain and the the hall window was open, resulting in the resident in room V3 offering complaints of feeling cold. The Findings include: During observation on 2/10/25 at 10:09 AM room X6 tiles under the bed were broken and chipped. During observation on 2/10/25 at 10:15 AM room X3 tiles under the closet were damaged. During observation on 2/10/25 at 10:16 AM room V1 had a cracked wall at the bottom right corner of window. During observation on 2/12/25 at 12:16 PM room V3, resident complained it was cold and the thermometer in the room registered 74 degrees. The hall window was open and blowing cold air into the room. During observation on 2/12/25 t 12:17 PM room S3 window curtain was hanging off the window. There was no documented evidence of a work order logbook with receipts from 8/20/24 and 10/10/24. During observation on 2/12/25 at 12:19 PM, of North 2-unit rooms (S3, X1, X3, X6, V1, V3) and shower room with the Maintenance Director, they stated they had been working on the renovations for some time and had not finished the second floor where these rooms were located. The Maintenance Director stated the shower drain was not secure and had last been fixed 8 weeks ago but the drain continued to break. The Maintenance Director stated it may be the weight of some residents that caused the drain to break. The Maintenance Director stated room V3 had central heating and the thermometer was at 74 degrees. They stated staff needed to close and keep the window in the hall closed. During observation on 2/13/25 at 11:05 AM and 2/14/25 at 1:58 PM, the unit North 2 hallway window was open near room V3. During interview on 2/14/25 at 1:59 PM, certified nurse aide #14 and Rehabilitation Aide #12, stated they were not aware of who opened the hallway window near room V3 and stated they did not open it. During interview on 2/14/25 at 2:01 PM, Registered Nurse #13 stated they were not aware of the window being opened and did not know who opened it. Registered Nurse #13 stated the window may have been opened for fresh air after providing care, but should have been closed. 10 NYCRR 415.5(h)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214 Based on observation, interview, and record review during the Recertification Survey from 2/10-2/14/25 the facility did not ensure comprehensive person centered care plans were developed for 1 of 3 residents (#37) reviewed for Limited Range of Motion. Specifically, Resident #37 did not have a care plan with goals and interventions specific to the use of a cervical collar. The findings include: The Facility Policy titled Comprehensive Care last reviewed 7/2/2024, documented the facility will develop and implement a comprehensive person centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident #37 was admitted with diagnoses including but not limited to Alzheimer's Disease, Fracture, and Heart Failure. The Nursing Progress Note dated 1/4/25 documented Resident #37 was received at the facility at 4:30 PM, cervical collar in place. Cervical collar to be kept in place until follow up with neurosurgeon. The Nurse Practitioner Note dated 1/5/25 documented Resident #37 admitted status post fall with C2 fracture and right pelvic fracture. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #37 had severely impaired cognition, and required maximum assist/was dependant for activities of daily living. The Physician Order dated 1/29/25 documented keep cervical collar in place until neurosurgery follow up and evaluate skin integrity under cervical collar daily and as needed every shift. There was no evidence of a comprehensive care plan specific to fractures, positioning, cervical collar, or skin integrity monitoring related to cervical collar use. During observation on 2/10/25 at 1:12 PM and 2/12/25 at 11:49 AM, Resident #37 was sitting up in the wheelchair with a cervical collar in place. During observation on 2/13/25 at 8:52 AM, Resident #37 was in bed with a cervical collar in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 1:07 PM Registered Nurse Unit Manager #10 stated there should be a care plan with goals and interventions specific to the use of a cervical collar, but was not able to locate such care plan. They stated they were able to locate an assessment that documented the fractures under the evaluations section of the reactivated activities of daily living care plan dated 9/27/24, but no new goals or interventions were added since the most recent admission on 1/4/25. They stated they had obtained the order that was present in the electronic medical record to monitor the skin and keep the collar in place when they were working on the unit on 1/29/25, but they were not completing care plans for the unit at that time. 10NYCRR 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214 Based on observations, interview, and record review during the recertification survey from 2/10/25-2/14/25, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 of 1 (Resident # 15) residents reviewed for pain management. Specifically, there were multiple omissions on the medication and treatment administration records for medications and treatments related to pain management for Resident #15. The findings include: The policy titled Administering Medications dated 4/20/2021 documented medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication will document that the medication was administered. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document the refusal. Resident #15 was admitted to facility with diagnoses that included Coronary Artery Disease, Hypertension, and Peripheral Vascular Disease. The Comprehensive Care Plan titled Pain Management updated 1/2/25, documented potential pain and intermittent pain related to activity level, monitor for pain, administer medication as ordered, and monitor effectiveness of medications. The Physician Order dated 12/31/24 included Gabapentin oral capsule 300 mg 2 capsules by mouth every 8 hours, Lidocaine External Patch 4% 2 patches every day, Capsaicin External Cream 0.025% apply to leg twice daily, and pain monitoring every shift. The Admission Minimum Data Set, dated dated dated [DATE] documented pain of 9/10 almost constant, affecting sleep and therapy. The January 2025 Treatment Administration Record had omissions for Capsaicin Cream on 1/2, 1/6, 1/10, 1/13, 1/14, 1/15, 1/20, 1/26, and 1/27/25. There was no documented evidence that explained the reason for omissions. The January 2025 Medication Administration Record had omissions for Gabapentin on 1/2, 1/10, 1/13, 1/14, 1/20/25, Lidocaine Patch on 1/2, 1/13, 1/14, 1/20/25, and pain monitoring on 1/2, 1/13, 1/14, and 1/20/25. There was no documented evidence that explained the reason for omissions. The February 2025 Treatment Administration Record had omissions for Capsaicin Cream on 2/3, 2/6, 2/7, and 2/10/25. There was no documented evidence that explained the reason for omissions. During an interview and observation on 02/10/25 at 03:30 PM, Resident #15 verbalized pain and stated they had received some pain medication but were still in pain. Nurse was informed of resident reports of pain and observed discussing with resident. Gabapentin was documented as administered at PM as ordered and pain monitoring was documented for shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/25 at 11:37 AM, Resident #15 stated they felt their pain management was overall effective with the suboxone and Tylenol. Resident #15 stated they believe they were in so much pain a few days prior because they worked too hard in therapy. During an interview on 02/14/25 at 09:52 AM Registered Nurse Unit Manager #10, stated Resident #15's pain was managed with Suboxone and Tylenol. They acknowledged there were omissions for the Capsaicin Cream, Gabapentin, and Lidocaine in January and/or February 2025. They stated the medication nurse should have documented the reason for the medications not being administered. They stated they had requested that the medication nurses check their records for omissions prior to the end of their shift. During an interview on 02/14/25 at 10:52 AM, the Director of Nursing stated the expectation was no omissions on the medication or treatment administration records. The Director of Nursing stated if a medication was not administered, the medication nurse should document the reason why the medication was not administered in a progress note or on the medication or treatment administration record 10NYCRR 415.12

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47626 Based on staff interview and record review during the recertification survey from 02/10/25 through 02/14/25, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, three of five Certified Nurse Aides (#2, #3, #4) did not have a performance review documented at least once every 12 months. Findings include: There was no documented evidence that performance reviews were completed in the last 12 months for Certified Nurse Aide #2 with a hire date of 2020, Certified Nurse Aide #3 with a hire date of 2018 and Certified Nurse Aide #4 with a hire date of 2017 During an interview on 2/13/25 at 10:42 AM the Human Resource Director stated unit supervisor/s were responsible for completion of Certified Nurse Aide performance reviews. The Human Resource Director stated Certified Nurse Aide performance reviews should be filed in employee folders, once completed. The Human Resource Director stated they did not realize Certified Nurse Aide performance reviews were not completed for Certified Nurse Aide #2, #3 and #4. During an interview on 2/13/25 at 10:44 AM the Assistant Administrator stated they were unsure why Certified Nurse Aide performance reviews were not completed for Certified Nurse Aide #2 ,#3, and #4. During an interview on 2/13/25 at 10:47 AM the Assistant Director of Nursing stated they helped with the completion of Certified Nurse Aide performance reviews in the past and thought they had been completed. 10NYCRR 415.26 (c) (2) (iii

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50766 Based on record review and interview during the recertification and abbreviated surveys (NY00341482) conducted from 1/10/25 to 1/14/25, the facility did not ensure residents were free from significant medication errors for one of one residents (Resident #399) reviewed for Neglect and Medications. Specifically, staff administered a medication not physician prescribed to Resident #399 which resulted in Resident #399 being transferred to an acute care hospital for evaluation. The findings include: Resident #399 was admitted with diagnoses including but not limited to Chronic Hepatitis C, Diabetes Mellitus, and Liver Cirrhosis. The facility policy titled Administering Mediations dated 4/20/21 documented: medications are administered in a safe and timely manner, and as prescribed. The individual administering medications verifies the resident's identity before giving the resident their medications. Methods of identifying the resident include: a. checking identification band; checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. a. allergies to medications; and b. vital signs, if necessary. The Discharge Minimum Data Set (a resident assessment tool) dated 5/6/24 documented Resident #399's short-term memory was intact. The Care Plan titled Psychoactive Medications, dated 5/6/24, documented: resident on an anti-psychotic, anti-depressant, anti-anxiolytic, or hypnotic medication for disease process. Resident will have no negative side effects from the medication, administer medications as per orders. The Investigation Report findings documented: At 12:30 pm on 5/8/24, the registered nurse notified the charge nurse of a medication error, they administered another resident's methadone 150 milligrams by mouth. The charge nurse immediately went to interview the resident and inform them of the medication error, the resident girlfriend was at the bedside. Resident Identification band and photo identification were present. Vital signs obtained. No signs or symptoms of nausea, dizziness or respiratory distress noted. Charge nurse immediately informed the director of nursing and nurse practitioner. Orders received to send the resident to the local hospital for evaluation and observation. Resident sister and mother called and arrived at the facility where they met with social worker, charge nurse and registered nurse supervisor and were informed of the incident. Family in agreement with emergency room transfer. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident/accident statement from Registered Nurse #9 documented residents medication was pulled. The alarm of a tube feed went off. Medications were placed in the cart and locked. When this registered nurse returned to the cart the alarm for the pump for another resident went off. Registered nurse went to turn off the alarm. Then the registered nurse refreshed the page on the electronic medical record and went to Resident #399. Resident #399 was with a visitor, but they gave permission for the registered nurse to enter. Registered nurse told the resident what the medication was, and the resident took the pills. Registered nurse took resident's blood pressure and left. Then the registered nurse went back to the cart and refreshed the electronic medical record page and realized the medication methadone was given to the wrong resident. The registered nurse went to the unit manager to report the error. The Investigative Conclusion documented registered nurse failed to follow policy and procedures for medication administration. The investigation revealed that this was a medication error on part of the registered nurse who failed to notice the resident's identification band, photo identification and confirm resident name prior to medication administration, along with resident name on the methadone that they administered to the resident. Resident's identification band present, room label on door present, photo identification and methadone was properly labeled with name of appropriate resident. The Plan to prevent reoccurrence/facility wide plan documented: resident sent to hospital. Nursing staff (registered nurse and licensed practical nurse) will be re-educated on medication administration policy and in-serviced on medication administration and resident medication rights. During an interview on 2/13/25 at 1:01 PM Licensed Practical Charge Nurse #8, stated Registered Nurse #9 presented to them at 12:30 pm on 5/8/24_to report they had incorrectly administered medication (Methadone 150 milligrams by mouth) to the wrong Resident (Resident #399). Licensed Practical Nurse #8 stated they immediately presented to Resident #399 upon receipt of the reported medication administration error. They stated Resident #399 was alert and oriented during interview and reported they had taken methadone in the past outside of the facility and did not feel unwell. They stated the nurse practitioner was contacted and provided orders to send Resident #399 to the local emergency room for evaluation. Resident #399 and family agreed with transfer to the emergency room . The director and assistant director of nursing were also made aware within 30 minutes of Registered Nurse #9 reporting the medication error. Licensed Practical Nurse #8 stated there was a photo of Resident #399 on the electronic medication record which should have been used to identify the resident and that Resident #399 also had an identification wristband on, and name on the door to the resident room. They stated the resident that the medication was prescribed for was in a separate room cluster halfway down the hall. They stated when Registered Nurse #9 reported the medication error to them, they stated they were being distracted by tube feeding alarms. Licensed Practical Nurse #8 stated that during the interview, Resident #399 stated they were informed by Registered Nurse #9 what medications were being administered and that Resident #399's girlfriend, who was present during medication administration and assessment, thought Registered Nurse #9 stated metformin (which resident was prescribed) and not methadone. They stated Resident #399 stated they were aware that Registered Nurse #9 stated methadone and did not question the medication administration. They stated Resident #399 did not return to the facility after presenting to the local emergency room for evaluation (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/25 at 5:27 PM the Director of Nursing, stated Registered Nurse #9 immediately reported the medication administration error to the charge nurse on the unit. The resident was interviewed by the unit charge nurse, facility nurse practitioner and the director and assistant director of nursing were notified. They stated the nurse practitioner provided an order for Resident #399 to be sent to the local emergency room for evaluation due to the resident receiving a narcotic medication that was not ordered for them. The Director of Nursing stated they considered this occurrence a significant medication error. They stated they contacted the local emergency room and provided the information involved in the medication administration error. The Director of Nursing stated an immediate investigation was started including medication review, staff statements, checking Resident #399's identification wristband, photo identification on the electronic medical record, room door label, and that all medications involved were properly labeled. The Director of Nursing stated they contacted the local hospital 48 hours after the resident was transferred and was informed that Resident #399 was discharged to the community after evaluation. 10 NYCRR 415.12 (m)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49364 Based on observation and interview conducted during the recertification survey from 2/10/25 through 2/14/25 the facility did not ensure food was stored in accordance with professional standards for food service safety. Specifically, beverages stored in nutrition and storage refrigerator/s were not labeled and were outdated, and a parcel of flour was left open not dated on the shelf. Findings include: The facility policy titled Food Receiving and Storage dated 6/26/2028 documented dry foods that are stored in bins will be removed from the original package, labeled and dated (use by date). Beverages must be dated when opened and discarded after 3 days. Other opened containers must be dated and sealed or covered during storage. An initial tour of the kitchen was conducted on 2/10/25 at 9:50 AM and the following were observed: - unlabeled 4 ounce cups were filled with white liquid dated 2/4, in the nutrition and storage refrigerator. - unlabeled 4 ounce cups were filled with brown liquid dated 2/4, in the nutrition and storage refrigerator. - unlabeled 4 ounce cups with thickened yellow liquid dated 2/10, on a tray. - an open parcel of all purpose flour that was open and not sealed. During an interview on 2/10/25 at 9:41 AM, [NAME] Supervisor #11 stated the white beverage in the 4 ounce cups were Lactaid milk, 4 ounce brown beverages were prune juice and the thickned yellow liquids were smoothies. [NAME] Supervisor #11 also stated the Lactaid milk and prune juices were outdated and should have been discarded after 3 days. [NAME] Supervisor #11 stated they were short staffed over the weekend and that was why the liquids were still in the refrigerator. During an interview on 2/11/25 at 9:55 AM, the Food Service Director stated the Lactaid milk and prune juice were supposed to stay in the refrigerator for 3 days, and usually they are labeled with L for Lactaid milk and A for apple juice.The Food Service Director stated the open parcel of flour that was observed on 2/10/25 was left open and should have been sealed. 10 NYCRR 415.14 (h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335750	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fishkill Center for Rehabilitation and Nursing	22 Robert R. Kasin Way Beacon, NY 12508

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49364 Based on observation, record review and interview conducted during the recertification survey conducted 2/10/25 through 2/14/25, the facility did not ensure proper disposal of garbage and refuse. Specifically, the garbage compactor /dumpster was left open and there were large metal containers, old furniture, and debris on the ground around the dumpster. The findings are: The facility policy titled Food-Related Garbage and Rubbish Disposal dated 6/26/24 documented all garbage and rubbish containers should be provided with tight fitting lids or covers and must be kept covered when stored. Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter. During an observation on 2/12/25 at 10:10 AM: -cardboard boxes in the dumpster and the dumpster was left open. -compactor was filled with old furniture and was left open -old furniture, large metal containers and debris were on the ground around the dumpster. During an interview on 2/14/25 at 9:31 AM, the Administrator stated the maintenance department were responsible for ensuring the dumpster was closed and that there was no garbage on the ground in the area. During an interview on 2/14/25 at 9:35 AM, the Director of Maintenance stated they had called the company to pick up the compactor, because it was full but were still waiting for the company to empty the compactor. The Director of Maintenance stated the large metal containers were donations and were awaiting pick up. The Director of Maintenance stated the old furniture was on the ground because the compactor was full, and they could not stop renovations. During a follow-up on 2/14/25 at 9:49 AM, the Director of Maintenance stated they had just called the company to come out and empty the compactor, but they would not be available until 2/25/25. They also stated they asked for a dumpster replacement lid but would not receive a lid until 2/25/25. During an interview at 9:55 AM, the Food Service Director stated they were not responsible for ensuring the dumpster was covered and were not responsible for ensuring garbage was not left in the area. They stated the Maintenance Director was responsible and concerns had been reported to them. 10 NYCRR 415.14(h)

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	335750	A. Building B. Wing	02/14/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on record review and interview during the recertification survey conducted 02/10/25-02/14/25, the facility did not ensure each resident was offered pneumococcal immunizations and received education regarding the benefits and potential side effects of the immunizations for 2 of 5 residents (Residents #9, #50) reviewed. Specifically, there was no documented evidence Resident #9, and Resident #50 were offered, declined, or educated about the pneumococcal immunization. Findings include: The facility policy for Pneumococcal Vaccination dated 10/01/2007 and last reviewed 1/4/2025 documented, in order to prevent the spread of infectious disease and to mitigate the risk of morbidity and mortality associated with pneumococcal pneumonia, the facility will offer pneumococcal vaccinations to all residents and staff. Resident #9 had diagnoses including Morbid Obesity, Type II Diabetes Mellitus and Major Depressive Disorder. The Minimum Data Set, an assessment tool, dated 12/2/24 documented the resident was cognitively impaired, ate with assistance and was dependent on staff for dressing and toileting. There was no documented evidence the resident/resident representative received education, was offered the vaccination, or declined the pneumococcal vaccine. Resident #50 had diagnoses including Chronic Obstructive Pulmonary Disease, dementia and Schizophrenia. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment and was dependent on staff for assistance with all activities of daily living. There was no documented evidence the resident/resident representative received education, was offered the vaccination, or declined the pneumococcal vaccine. During an interview on 2/13/25 at 3:27 PM, the Director of Nursing stated they were the Infection Preventionist and were responsible for the vaccine program and were supposed to document each resident's vaccine status when admitted to the facility. The Director of Nursing stated they had not been keeping a close eye on the pneumococcal vaccines for residents and had not been tracking the vaccine information. They stated they needed to get a better handle on it because the vaccines were important for protection against disease. 10NYCRR 415.19 (a) (1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335750	A. Building B. Wing	02/14/2025

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41666 Based on interview and record review during the recertification survey conducted on 2/10/25-2/14/25, the facility did not ensure each staff and was screened, offered the most recent COVID-19 vaccine and provided education regarding the benefits, risks and potential side effects associated with the vaccine for 10 of 10 staff reviewed for COVID vaccines. Specifically, there was no documented evidence Staff were offered, and education was provided for COVID vaccination for Dietary Aide #15, Housekeeping #16, Certified Nurse Aide #17, #18, #20, Licensed Practical Nurse #19, Registered Nurse #21, Social Worker #22, Dining Supervisor #23 and [NAME] #24. Findings include: The facility policy titled Management of COVID-19 and dated 11/30/24, documented the facility will offer consenting personnel the opportunity to receive any dose of the COVID-19 vaccine. Signage throughout the facility reminding personnel and residents that the facility offers COVID-19 vaccination will be posted. During an observation on 02/13/25 at 3:56 PM there were no visible signage promoting COVID-19 vaccination. During the recertification survey the facility was asked to provide documentation that COVID-19 vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for Dietary Aide #15, Housekeeping #16, Certified Nurse Aide #17, #18, #20, Licensed Practical Nurse #19, Registered Nurse #21, Social Worker #22, Dining Supervisor #23 and Cook#24 but non was provided. During an interview on 02/13/25 at 1:34 PM with Licensed Practical Nurse #25 they stated they got their annual flu shot at the facility in the fall but was not offered and did not hear anything about the COVID-19 shot. They stated it was a good idea to get the COVID-19 vaccine to protect themselves and the residents and if it was offered at that time, they would have consented to it. During an interview on 02/13/25 at 3:44 PM the Assistant Director of Nursing stated they were responsible for the staff vaccines including COVID-19 boosters and did not think to offer COVID-19 vaccines because there had been a lack of interest amongst the staff. They stated they had done education with the staff but could provide any documentation and stated it was important for staff to be educated about vaccines because it was a way to protect staff and residents from getting COVID-19. During an interview, on 2/13/25 at 3:27 PM, the Director if Nursing stated they had not been keeping track closely on the vaccines and needed to work on obtaining vaccine status for residents and staff for offering, educating and obtaining declinations. They stated they did not know what happened to the signage throughout the facility reminding personnel and residents that the facility offered COVID-19 vaccination, and stated it should have been posted. 10NYCRR 415.19 (a)(1-3)