STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335763	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Vincent Depaul Residence	900 Intervale Avenue Bronx, NY 10459

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 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. 48711 Based on observations, record review, and interviews conducted during the Recertification Survey from 01/02/2025 to 01/08/2025, the facility did not ensure that the last 3 years of facility survey results were posted in a place readily accessible to residents, family members, public, and legal representatives of the residents, where individuals wishing to examine survey results do not have to ask to see them. This was evident for 5 (#15, #49, #96, #29, #42) out of 11 residents attending the Resident Council meeting. Specifically, survey results were posted at the resident courtesy phone located on the left-hand side of the unit, not in plain view. The findings are: The facility policy titled Posting and Availability of Survey Results and Complaint Investigations effective 01/2025 documented the facility is committed to transparency and regulatory compliance by: Posting the results of the most recent survey in a location readily accessible to residents, family members, and legal representatives. Making survey reports, certifications, and complaint investigations from the past three years available upon request. Posting a notice in prominent areas to inform individuals of the availability of these documents. On 01/02/25 at 10:02 AM, The Department of Health Survey results are displayed on the wall adjacent to the security front desk in a blue binder that included the following surveys: 11/2/2023 survey results of Life Safety Code that was done on 9/5/2023. 10/3/2023 survey results of Recertification and Complaint Surveys performed on 08/07/023, 06/28/2023 results of Complaint Survey and 03/27/2023 to 3/29/2023 results of Complaint Survey. On 01/02/2025 and 01/03/202524 between 10:00 AM and 11:00 AM, a sign was posted in a cubby area located near the resident courtesy telephone on the left-hand side coming off the elevator in a non-visible area on Units 2, 3, and 4. Multiple observations were conducted on Units 2, 3, and 4 on 01/02/2025 and 01/03/2025 and there were no documented evidence that the last 3 years of Recertification Survey results were posted. Observed to be posted was survey results from 11/2/2023 of Life Safety Code, 10/3/2023 survey results of Recertification and Complaints, 06/28/2023 survey results of Complaint Survey and 3/27/2023 to 3/29/2023 Complaint Survey results. There was no evidence that the survey results from the year 2022 was posted. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of the last 3 months of the Resident Council Meeting Minutes revealed there is no documented evidence that the location or the postings of the survey results were discussed at the Resident Council Meetings. On 1/3/2024 at 10:15 AM, a Resident Council Meeting was held with 11 residents. Resident #15, #49, #96, #29, and #42 stated during the meeting they do not know where they can find the survey results without asking. On 01/08/2025 at 11:50 AM interview with the Administrative Coordinator stated you are right, the last 3 years of the results of the survey should have been posted since 2022. On 01/08/25 at 12:20 PM interview with the Director of Nursing stated the survey results are usually posted on all the units. It is usually 3 years of postings. On 01/08/2025 at 02:19 PM the Administrator was interviewed and stated, the survey results are discussed in the minutes in resident council meetings and on admission as well. There is a sign of the posting of the survey results downstairs and near the courtesy phone. 415.3(1)(c)(1)(v)

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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. 44843 Based on interviews and record review conducted during the Recertification Survey from 01/02/2025 to 01/08/2025, the facility did not ensure residents, or their designated representatives were provided appropriate notification at the termination of Medicare Part A benefits. This was evident in 2 (Resident #36 and Resident #55) of 3 residents reviewed for Beneficiary Notification out of 23 total sampled residents. Specifically, the facility did not ensure that Notice of Medicare Non-Coverage were mailed to the residents' representatives on the same day telephone notification was made. The findings are: The facility policy titled Advanced Beneficiary Notice of Medicare Non Coverage Benefit Exhaust Letters with effective date 9/14 and last revision date of 12/23 documented the Advanced Beneficiary Notice required by the Centers of Medicare and Medicaid services are distributed to residents within the required time frames. The policy also documented the Benefit Exhaust Letters are sent to Residents/Representatives to inform them that Medicare A is no longer covering the skilled stay. The policy further documented to mail notice if necessary, following phone call under the section of Procedure. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 states that the form must be delivered at least two calendar days before Medicare covered services end and included the requirement that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. The instructions also stated that if the provider is personally unable to deliver a Notice of Medicare Non-Coverage to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise them when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. The instructions also state that when direct phone contact cannot be made, the notice should be sent to the representative by certified mail, return receipt requested. 1) Resident #55 was discharged from Medicare skilled services on 07/17/2024 and remained in the facility. The Notice of Medicare Non-Coverage documented that Resident #55's designated representative was called on 07/15/2024 and a voice message was left. The Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage documented Resident #55's designated representative was called on 07/15/2024 and informed that Resident #55's coverage will end on 07/17/2024. There was no documented evidence that the notices were mailed to Resident #55's representative on the same day that telephone notification was made. 2) Resident #36 was discharged from Medicare skilled services on 11/4/2024 and remained in the facility. The Notice of Medicare Non-Coverage and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage documented Resident #36's designated representative was called on 11/1/2024 and informed that Resident #36's coverage will end on 11/4/2024. There was no documented evidence that the notices were mailed to Resident #36's representative on the same day that telephone notification was made. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/2025 at 09:09 AM, Minimum Data Set Coordinator was interviewed and stated they had a utilization review meeting every week to discuss the resident discharge from Medicare Part A. Minimum Data Set Coordinator also stated that residents who will be discharged from Medicare Part A services are given at least 48-hour notice and that their right to appeal is explained. Minimum Data Set Coordinator stated that if a resident is cognitively intact, they ask them to sign the Notice of Medicare Non-Coverage and/or the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage. Minimum Data Set Coordinator also stated that if a resident is cognitively impaired to make decisions, they notify the resident's designated representative by phone call and did not mail them the notices unless the representatives requested the notices. Minimum Data Set Coordinator further stated they mailed the notices with certified mail receipt on same day if they were not able to reach the impaired resident's representative by phone call. Minimum Data Set Coordinator stated they spoke to the representatives of Resident # 55 and Resident # 36 and the representatives stated they did not want to receive the notices. Minimum Data Set had no proof of the refusal to receive the notices. On 01/08/2025 at 09:32 AM, the Administrator was interviewed and stated the Minimum Data Set Coordinator was responsible for providing Notice of Medicare Non-Coverage and/or the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage notices to residents and/or designated representatives to review and sign before discharging them from Medicare Part A. The Administrator also stated they should mail, email, or use other methods so the representative can receive the forms and keep a proof of it. 10 NYCRR 415.3(g)(2)(i)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on observation, interview, and record review conducted during the Recertification Survey from 01/02/2025 to 01/08/2025, the facility failed to maintain a clean, orderly, functional, and sanitary (homelike) environment for the residents. The deficient practice was identified for multiple resident rooms/units inspected: 1) room [ROOM NUMBER] had no hot water supply for about 3 weeks, 2) room [ROOM NUMBER] and shared shower room on Unit 3 were observed in disrepair/damaged/discolored/ dirt and dust accumulation, 3) 2nd floor dining room and rooms 201/202/210/211/212 were observed in disrepair/damaged/discolored. The findings are: The facility policy titled Hot Water Temperature with undated effective date documented the Department of Engineering is responsible for prompt follow-up on any problem, including investigation, repair or other action as appropriate. The facility policy titled Work Order Procedure with undated effective date documented this procedure will govern the insurance of engineering work orders for the safety, preventive maintenance, repair, facility modification and emergency work, indicating on what authority a work order needs to be approved, and prior to being scheduled into the department workload. 1) On 01/02/2025 during the initial pool process around 11:34 AM to 11:43 AM, and subsequent visit on 01/03/2025 around 10:38 AM to 10:43 AM, the surveyor conducted an environmental tour in the room [ROOM NUMBER] and observed there was no hot water coming out when the handle of the hot water faucet was turned on at the sink in the bathroom. On 01/02/2025 at 11:34 AM, Resident # 57 was interviewed and stated there was no hot water from the sink in the bathroom of room [ROOM NUMBER] for 3 weeks. Resident # 57 also stated the sink fell and broke about 3 weeks ago. Resident # 57 further stated the facility installed a new sink the next day and there was no hot water since then. Resident # 57 stated the Certified Nursing Assistant and themselves had to go to the bathing room across the hallway to get hot water when needed and it was very inconvenient. On 01/02/2025 at 11:43 AM, Resident # 95 was interviewed stated there had been no hot water in the bathroom sink of room [ROOM NUMBER] since the facility replaced the broken sink about 3 weeks ago. Resident # 95 also stated the Certified Nursing Assistant and themselves had to go to the bathing room across hallway to get hot water. Resident # 95 further stated they needed hot water supply in the room to wash hands and other purposes in the wintertime. The maintenance book was reviewed and had no documentation about hot water supply problem in the room [ROOM NUMBER]. The Maintenance Repair Requisition form documented the sink in room [ROOM NUMBER] became loose on 12/4/2024. The form also documented by Maintenance Department on 12/5/2024 that a sink was reinstalled, waterline was tied in, and sink was in working condition. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/2025 at 09:29 AM, Certified Nursing Assistant # 5 was interviewed and stated they were assigned to Resident # 57 and Resident # 95 in the room [ROOM NUMBER] in December 2024. Certified Nursing Assistant # 5 also stated they were aware there was no hot water supply in the room [ROOM NUMBER] during the morning report meeting from the nurse in December 2024 and did not recall the exact date or which nurse gave the report. Certified Nursing Assistant # 5 further stated they thought the hot water issue was known to the nurse already and did not follow up on the repair of hot water issue in room [ROOM NUMBER]. Certified Nursing Assistant # 5 stated they should report to the nurse in a few days if there was still no hot water supply in the room [ROOM NUMBER]. On 01/07/2025 at 09:52 AM, the Housekeeper was interviewed and stated they recalled there was no hot water in room [ROOM NUMBER] at least since the last week of December 2024. The Housekeeper also stated they did not report the problem to anyone as they saw someone was fixing the sink and was not sure who was fixing the sink. The Housekeeper further stated they thought the hot water problem was taken care by someone already. On 01/07/2025 at 03:40 PM, Certified Nursing Assistant # 6 was interviewed and stated they were newly hired and worked in the evening shift on the unit for a few weeks. Certified Nursing Assistant # 6 also stated they shadowed Certified Nursing Assistant # 7 and were assigned to residents in room [ROOM NUMBER]. Certified Nursing Assistant # 6 further stated they recalled the room [ROOM NUMBER] had no hot water supply at least starting the last week of December 2024. Certified Nursing Assistant # 6 stated they did not report the disrepair as they thought Certified Nursing Assistant # 7 was going to report the disrepair. On 01/07/2025 at 10:01 AM, Registered Nurse # 4 was interviewed and stated they made rounds on the floor at least 3 times a day to check if resident's room and bathroom were clean, resident care, and resident safety. Registered Nurse # 4 also stated they did not check water supply in the resident rooms and was not aware nor received any report that there was no hot water in the room [ROOM NUMBER]. Registered Nurse # 4 further stated they were not aware the Maintenance Department changed the sink in room [ROOM NUMBER]. Registered Nurse # 4 stated they would transfer both Resident # 57 and Resident # 95 to another room if they knew there was no hot water in the room [ROOM NUMBER]. Registered Nurse # 4 also stated there were empty rooms on the unit for a transfer if needed. On 01/07/2025 at 03:16 AM, the Maintenance Mechanic staff was interviewed and stated the unit staff called them for urgent repairs and documented non-urgent repair in the maintenance book. The Maintenance Mechanic staff stated they replaced the sink in room [ROOM NUMBER] on 12/5/2024. The Maintenance Mechanic staff also stated there was no problem for both hot and cold water supply in the room [ROOM NUMBER] before they left. The Maintenance Mechanic staff further stated they did not receive any report that there was no hot supply in the room [ROOM NUMBER] afterward. On 01/07/2025 at 10:14 AM, Director of Plant Operation and Maintenance was interviewed and stated the sink in the room [ROOM NUMBER] fell on [DATE] and they replaced a new one next morning on 12/5/2024. Director of Plant Operation and Maintenance also stated they did not receive any report until 1/3/2025 that there was not hot water coming out in the sink of room [ROOM NUMBER]. Director of Plant Operation and Maintenance stated they checked the issue and found out it was the speedy valve problem in the pipe running hot water to the room [ROOM NUMBER]. Director of Plant Operation and Maintenance also stated they would have the outside plumber to fix the problem if they were notified of the hot water problem in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/2025 at 11:52 AM, the Administrator was interviewed and stated they were not aware there was no hot water supply in the room [ROOM NUMBER] until 1/3/2025. The Administrator also stated every room should have a hot water supply. 48711 2) During the Unit Tour on 1/3/2024 and 1/7/2025 of Unit 3 the following was observed: room [ROOM NUMBER] the wall behind the resident bed has multiple, deep, scratches with white substance exposed on the wall. The brown headboard has scrapings on it. Panel molding coming off the base of the floor. Located behind the entrance door is a large, white, spot, surrounded by pink colored paint. A review of the Unit 3 Maintenance log found no documented evidence that room [ROOM NUMBER] and the resident shared bathroom was in need of repairs. Resident shared shower room on Unit 3 was observed to have broken yellow tiles in the shower stall, shower head on the floor due to missing clamp holder, brownish to black substance observed in the corners of the shower stall and on the white wall tiles. [NAME] screen with dust on them, dead bees lying on the floor and brown colored stains observed on the white ceiling tiles. On 1/7/2025 at 12:25 PM interview with Maintenance Technician and stated the office management located on the 5th floor is responsible for doing a walkthrough of the resident rooms. The management staff consist of nursing, directors, and management. They will assign staff to go into the rooms to see what is going on. The maintenance logs are used for the overnight staff when on one is around. In the morning, the staff will call me, and I will come to see what needs repairing. My job is to make repairs, paint, fix lights, windows, fix the tiles and walls and any repairs that need to be done. Not aware of any of the listed items that need repair. On 01/07/25 at 01:54 PM the Director of Housekeeping and Maintenance was interviewed and stated, it is their responsibility to ensure that the common areas, hallways, and resident rooms are clean and in good repair. The rounds are done on a weekly basis by the Director of Housekeeping and Maintenance and nursing department. There are maintenance logs on every unit and those logs get check every morning by the maintenance workers. The Housekeeper on the unit is also supposed to check for any environmental issues and report as needed. On 01/07/2025 at 03:00 PM Registered Nurse #4, who is also the Nursing Supervisor for Unit 3, was interviewed and stated, that the nursing staff and supervisors make rounds of the unit daily to see if there are any issues and any need of repairs and write it in the maintenance logbook for maintenance to address. 42101 3). During observations made from 1/2/2025 at 3:34PM through 1/8/2025 at 12:28 PM, the following was observed on the 2nd Floor Unit: a. On 01/02/2024 at 3:34 PM, 01/02/25 03:44 PM, 01/03/25 12:05 PM, 01/06/25 11:16 AM, and 01/08/25 10:08 AM the 2nd Floor dining window screen lower bottom edge cracked. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 01/02/25 12:47 PM, 01/03/25 09:44 AM and 01/08/25 10:25 AM, room [ROOM NUMBER] Air conditioning/heater was noted with debris inside that included a sugar wrapper, purple crayon, dust coils left side and vents, and the room was noted with missing baseboard forming gaps along the room wall edges and behind headboard for B bed. c. On 01/02/25 12:42 PM, 01/02/25 03:23 PM, 01/03/25 09:47 AM, 01/08/25 10:28 AM, 01/02/25 12:42 PM, 01/02/25 03:23 PM, 01/03/25 09:47 AM, 01/08/25 10:28 AM - room [ROOM NUMBER] was observed with air conditioning/heater unit that was dusty. Baseboards in room coming off wall by the dresser between the A and B beds, peeling baseboards not affixed to the wall under Bed B headboard, by closet not affixed to wall and by door leading to the bathroom. Scratched dry wall observed in room to left of headboard. Baseboards not affixed to wall, peeled under headboard and by closet not affixed to wall and by door leading to bathroom not affixed to wall. d. On 01/02/2025 at 09:49 AM and 01/08/25 10:31 AM, room [ROOM NUMBER] footboard on bed veneer scratched on top, sides, outside and bottom edges and bathroom pipe faucet dripping water and left faucet could not be closed to stop water from dripping. e. On 01/03/2025 at 09:53 AM, room [ROOM NUMBER] was observed. Resident room baseboard behind headboard not affixed to wall and the dry wall behind headboard damaged, missing paint. Fall matt with curled edges on all 4 ends. f. On 01/02/25 03:41 PM and 01/03/25 09:57 AM and screen the same., room [ROOM NUMBER] - room window screen torn on left edge in 2 areas making up greater than 1/2 of the left side, missing rubber right side area, air conditioner/heater unit with 2 round items on top, g. On 01/07/25 at 03:43 PM - Fly noted flying in the dining room on the 2nd floor. On 01/08/25 10:43 AM black fly flying in 2nd floor hallway by nurses station leading to dining room. h. On 01/07/25 at 03:44 PM and On 01/08/25 at 10:12 AM the 2nd floor dining room pantry was observed and there was white colored granules on the corners and back of the left and right shelves and black colored stain on the outer edge of the middle right cabinet outer edge. On 01/08/25 10:58 AM, Certified Nursing Assistant #3 was interviewed and stated they had not noticed the window and due to it being cold they try not to expose residents too much to the cold air outside. The window is defective, and the end is broken and most of the time maintenance comes around the unit. The window looks like it has normal wear and tear. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/08/2025 at 11:10 AM and 2:46PM, the Maintenance tTechnician was interviewed and stated that they only correct issues when they have a work order. If staff don't notify them they do not know an issue had to be fixed. The Director of Plant Operations and Maintenance is in charge of checking for environment issues. The air conditioning/heater were looked at recently and the Facilities Director has the paperwork. The window screens have been there since 1992 and they did not notice issues with resident window screens that are damaged. The only way they are aware of anything that needs to be fixed is when reported to them or if they are notified by nursing staff. Someone came to look at window screens recently and the window screens do not close all the way. The bed in room [ROOM NUMBER] needs to be replaced and the water valve for hot water is bad and needs to be replaced. The air conditioning/heater was cleaned recently, and the Facilities Director has paperwork. Housekeeping can also clean the air conditioning/heater unit and if they need help with loosening the screws they can contact them. The resident's rooms need to be homelike since they live here. Any work done is done per a work order and if no work order they will not know what needs to be fixed. The last time they looked at the room baseboards was before November 2024. In relation to the spacing between the baseboards, the glue used was wrong and the last time the baseboards were worked on was 3 1/2 to 4 years ago and whoever installed them did it wrong. They are not sure when the window screens were last looked at and they have worked on the screens in the past they have changed the wire mesh to a plastic mesh in some areas. They look at the screens for holes and they look at the windows in resident rooms to see if they are damaged and the work on the windows. Resident can open the windows and damage the screens. They painted some room walls recently about 2 weekends ago. When the windows are damaged insects such as mosquitos and leaves can come into resident's rooms and the facility. There are only 2 maintenance persons for the building. Flies come in when we open the window and since the mesh does not close all the way they come in from outside. Staff should engage the latch to make sure the windows close completely. On 01/08/25 at 12:06 PM, the Director of Plant Operations and Maintenance was interviewed and stated the do rounds weekly. They do rounds on the 4th floor on Friday and round the other floors on Monday to Thursday. They look at residents rooms to include ceiling tiles, walls to make sure they are not damaged since residents beds can hit the wall behind causing scrapes and peeling paint. The air conditioning/heater units they check when they go check resident rooms and the last time they checked they documented it in their rounding binder. The air conditioning/heater units were cleaned last week and all air conditioning/heaters were cleaned throughout the facility and they are unsure of the date it was done. There was an audit list of the window screens done 1 month ago throughout the building and the vendor is coming to repair the ones on the list to be repaired and some window screens are damaged or missing and had to be taken down due to this damage. The air conditioning/heater are working, and we make sure it has the outer piece and are wiped down. We have a list of units that have concerns and are in the process of addressing that. The Director of Plant Operations and Maintenance stated work was done 2-3 months ago on the air conditioning/heater units and they will provide invoices for window work. 10 NYCRR 415.5(h)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44842 Based on observations, record reviews, and interviews during a Recertification Survey from 1/02/2025 to 1/08/2025, the facility did not ensure that assessments accurately reflected the residents' status. This was evident for 2 (Resident #36 and Resident #6) out of 23 total sampled residents. Specifically, 1) The Minimum Data Set 3.0 assessment did not document Resident #36's use of a Wanderguard and 2) The Minimum Data Set 3.0 assessment inaccurately documented Resident #6 as having clear speech, with ability to make self-understood. The findings are: The facility policy titled, Minimum Data Set Assessment Completion, last reviewed/revised 9/2023 documented, the interdisciplinary team will conduct comprehensive assessments as part of an ongoing process to identify each resident's preferences and goals of care, functional and health status, strengths, and needs, as well as offering guidance for further assessment once problems have been identified. 1) Resident #36 had diagnoses of Non-Alzheimer's Dementia, Schizophrenia, and Seizure Disorder. The Annual Minimum Data Set assessment dated [DATE] documented Resident #36 had severely impaired cognition and did not use a Wander/elopement alarm. On 1/02/2025 at 3:05 PM, 1/03/2025 at 9:39 AM, and 1/07/2025 at 10:59 AM, Resident #36 was observed with a Wanderguard to their right ankle. The Comprehensive Care Plan related to wandering and elopement initiated 9/20/2024 and last reviewed 12/21/2024, documented Resident #36 had a Wander Alert Bracelet to their right ankle. An Admission Nursing Note dated 9/21/2024 documented Wanderguard on Resident #36's right ankle per history of wandering behavior. The Physician Orders dated 9/21/2024 documented check Resident #36's Wanderguard placement/function every shift. 43350 2) Resident #6 was admitted to the facility on [DATE] with diagnoses including Aphasia and Dysphagia Following Cerebral Infarction. A Communication Care Plan was initiated for the resident on 09/02/2024 due to impaired ability to make self-understood secondary to slurred speech and was last reviewed 11/29/2024. However, the Minimum Data Set booklet dated 09/04/2024 documented the resident as having clear speech with ability to make self-understood. The Minimum Data Set booklet dated 11/29/2024 did the same. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Vincent Depaul Residence	900 Intervale Avenue Bronx, NY 10459

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/2025 at 10:58 AM, Resident #6 was observed seated in a wheelchair at the unit nursing station attempting to communicate with a staff member by rubbing their chin and shrugging their shoulders, then pointing to a passing aide. The staff member told the resident that they did not understand what the resident was trying to say, and the resident appeared frustrated, finally conveying through gestures only that they felt they had been shaved sloppily and would like an aide to go over their unshaven spots. On 01/07/2024 at 10:42 AM, Registered Nurse Supervisor #1 was interviewed and stated that Resident #6 had an unsuccessful trial of speech therapy following their admission but remained essentially nonverbal, able to grunt or scream but not to articulate words. The resident is cognitively intact and was subsequently provided with a communication board but refused to use it. They prefer to use gestures to convey their ideas, and most staff members have become adept at figuring out what their gestures mean. Those who aren't able call upon other staff until the resident's meaning becomes clear. On 01/07/2025 at 11:15 AM, the MDS Coordinator was interviewed and stated that Resident #6 and Resident #36's Minimum Data Set booklets were completed by the MDS Assessor, a Registered Nurse who was currently out on medical leave. The Coordinator stated that the nurse followed the progress notes, physician orders and care plans to fill out the booklets as well as meeting with the residents themselves. In the case of Residents #6 and #36, the Coordinator stated that they did not know how the nurse came to document their booklets so incorrectly as they are responsible for their accuracy but that the nurse is currently not available to discuss their line of thought. On 01/07/2025 at 1:54 PM, the Director of Nursing was interviewed and stated that the Nursing Department collaborates with the MDS Department in ensuring the accuracy of the information documented in the Minimum Data Set booklets. The MDS Coordinator directly oversees the MDS Assessor. 10 NYCRR 415.11(b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification Survey [DATE] -[DATE], the facility did not ensure that food was stored and prepared in accordance with professional standards for food service safety. Specifically, (1) there were boxes containing food stored past their use by/best by date. There was an open box containing mirepoix vegetable soup mix, an open box Capi vegetable blend, open box with coleslaw stored. There was also an open box containing expired raw frozen shrimp in the freezer. (2) a dietary staff with a beard and mustache was observed in the process of preparing food without a beard net. This was evident in the kitchen observation. The findings are: The facility policy titled Food and Supply Storage revised ,d+[DATE] documented all food used for food preparation shall be stored in such a manner as o prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Most, but not all, products contain an expiration date. The words sell by, best by enjoy by or use by should proceed the date The 'sell by date is the last date that food can be sold or consumed. Food past the use by, sell-by, best-by or enjoy by date should be discarded. Date and rotate items first in first out. Discard food past the use by or expiration date. The facility policy titled Food Handling Guidelines Hazard Analysis Critical Control Points (HACCP) revised , d+[DATE] documented food is handled using Hazard Analysis Critical Control Points process in accordance with regulatory guidelines. Proper handling procedures and techniques are visually monitored on an ongoing basis. The Director of Food and Nutrition Services/Dining Services and The Executive Chef are responsible for the execution and monitoring Critical Control Points and records associated with safe food handling procedures. The individual responsible for maintaining the records should initial the form weekly verifying that proper procedures are been followed. The policy only mentions the use of single use disposable gloves in food preparation and no other uniform items are mentioned for food preparation persons to wear. The facility policy titled Uniform Dress code revised ,d+[DATE] documented personal cleanliness and a neat appearance are essential for the food service worker. Facial hair must be kept neatly trimmed, hair must be neat and glean, good grooming and personal hygiene is mandatory. Restrain all facial hair with a beard net/restraint. Because everything on this subject cannot possibly be addressed, Associates with questions about the appropriateness of a particular items should speak with the manger before wearing certain articles. The facility in-service on hairnet and beard guards dated [DATE] documented 12 employees and 1 manager attended the training. The facility in-service on food safety and quality assurance dated [DATE] was signed by 9 dietary staff. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. An initial tour of the kitchen was conducted on [DATE] from 09:44 AM-10:10AM with the Director of Patient Food Services. The following were observed in the refrigerator: mirepoix veg soup mix ,d+[DATE] inch 4 x 5 pound use by [DATE] lot number167566, 4 bags of veg blend capri 5 way with lot number 169697 ,d+[DATE] pound box with a best if enjoyed by date of [DATE] and the open box dated [DATE], 1 ,d+[DATE] bags of coleslaw salad mix G/R cab/car 4 x 5 pound with a use by date of [DATE] lot number WO,d+[DATE] and the box was dated [DATE]. The following was observed in the kitchen freezer an open box containing frozen raw deveined white shrimp , d+[DATE] count with a best if used by [DATE] with product number 22124 and purchase order #P101423. During an interview on [DATE] at 10:14 AM, the Food Service Worker was interviewed and stated they did not look at the food items on the shelf. The facility gets food deliveries on Tuesday and Friday and looked at [DATE] with use by date of [DATE]. They stated the food items mirepoix veg soup, vegetable blend capri 5 way and coleslaw salad mix should not be on the shelf. They look at items in the refrigerator and the cook informs them in they will use the item or not. It is important that food is used timely, so it does not expire and make people sick. We use the older stock first and then we use the newer food items. They stated they have not had training on food safety yet. During an interview on [DATE] at 10:28AM, the Food Service Supervisor stated that they look at the refrigerator and freezer 3 times a day. They also look at the refrigerator and freezer when they get food deliveries on Tuesday and Friday. They did not notice that anything in the refrigerator and freezer were expired. They stated they worked yesterday and did not notice any expired items and they looked at the freezer yesterday and they did not notice the expired food items. The food items should not be in the refrigerator and/or freezer due to food contamination, don't want to create foodborne illness and they had food safety training 1 month ago. On [DATE] at 10:34 AM, [NAME] #1was interviewed and stated, the shrimp is not cooked and the last time they prepared shrimp was 5 months ago on their shift. [NAME] #1 stated that the night cook prepares the vegetables for the meals. They look at date on food items daily and they are not aware of any food items that are expired. When the food comes in, it is used up. We don't want to use expired food because we don't want to get residents sick and it is a hazard. On [DATE] at 10:48 AM, the Food Service Manager was interviewed and stated, they look at the refrigerator/freezer when they open the kitchen daily. When they look at food items, they look for the expiration date, food appearance, received date and rotate food items when needed by the food best by date. If the food item is closed item, then the discard date would be based by the foods shelf life. Food stored in the refrigerator is dated for 3 days and anything opened dated 3 days for items start use date. If the food items are in a box we go by the receive date. The mirepoix veg soup mix is in the box and for prepackaged food items received and from the day the food item is open it is labeled for 3 days so it can be discarded on day 3. If the food item is unopened, we go by the receive date and if a food item is closer to date of discard we go by manufacturer date. The best by and use by dates are similar and they are based on manufacturer term. They looked at the freezer yesterday and yesterday shrimp was on the menu and some residents may have an allergy to shrimp and there are alternative foods available for residents with food allergies. They are not sure of the last time they looked at the raw shrimp. Expired food items could get residents sick, and this is why we keep fresh items in house instead of spoiled that can make residents sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:23AM, the Director of Patient Food Services was interviewed and stated, that they look at the refrigerator and freezer every morning and also at night. They stated they never noticed the shrimp before, and it is a catering item. We use the raw shrimp right away and the item is used quickly, and they contacted the vendor, and the food item needs to have more shelf life. For food safety of the residents we need to make sure food items are used timely. Last in-service that was done was on food inventory which has to be rotated using first in first out. 2. On [DATE] at 10:47 AM-10:58 AM [NAME] #2 was observed with a beard and mustache on their face approximately ,d+[DATE] inch to 1 inch in length in the kitchen not wearing beard net in kitchen. [NAME] #2 was observed with a closed box of chocolate brownie mix which was later opened and placed in a silver bowl and grabbing a spatula opposite the stove and going back to the prep area on the office side of the kitchen. On [DATE] at 11:30 AM, [NAME] #2 was interviewed and stated, they had a beard net on earlier but removed it and they were suppose to have one on their face. They don't want any hair to go in the food. On [DATE] at 11:02 AM, the Food Service Supervisor was interviewed and stated, staff with facial hair are required to wear a beard net. If staff have ,d+[DATE] inch to 1 inch of hair on their face they should wear a beard guard. They did not notice staff without a beard guard. Hair can fall into the food and it should be covered at all times and should be worn when entering the kitchen as this is part of the staff uniform. On [DATE] at 11:26AM, the Director of Patient Food Services was interviewed and stated, dietary staff uniforms includes hair nets, beard guards and non-slip shoes are part of the uniform. Dietary staff need to wear and use hair nets and beard nets When preparing and handling food so no hair will get in the food, staff should be using hair and beard covers. We always make sure staff have on their hair nets/beard nets and we are adamant about this. On [DATE] at 11:39 AM, the Infection Preventionist was interviewed and stated, they do kitchen rounds less often at least once every 2 weeks. They look for infection control such as use of hair nets, beard nets. There were no issues with hair nets/beard nets. Hair nets and beard nets need to be worn to avoid cross contamination of the food. 10 NYCRR 415.14(h)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on interviews and record reviews made during a recertification survey (BYS411), the facility did not ensure that the Arbitration Agreement was explained to residents or their representatives in a form or manner that they understood. This was true in 3 of 21 residents sampled for Arbitration (Residents #22, 57 and 206). The findings are: The facility's policy and procedure entitled Admission Procedures, last reviewed 07/2019, states that the Admissions Director discusses the Admission Agreement with the resident and/or designated representative after admission to the facility. The facility includes a Binding Arbitration Agreement within its Admission Agreement which is written in legal language. The facility's admission packet was reviewed and revealed a brochure entitled, Your Rights as an ArchCare Resident which included the right to receive an explanation about care in a manner the resident can understand. On 01/07/2025 at 2:20 PM, the Admissions Director was interviewed and stated that when they explain the Arbitration Agreement, they let the resident know who they can talk to for legal advice and refers them to the corporate finance department for any questions. If the resident is unable to understand the legal language of the agreement, the Admissions Director stated that they read it out loud for them but do not paraphrase and stated, It's written for lawyers, but that's what we read. The Admissions Director stated that no one is obligated to sign as a condition of admission and that some residents do opt not to sign. The Surveyor obtained a list of recently admitted residents who had participated on their own or with their families in the admissions process. Resident #22 was admitted to the facility on [DATE] and as per their Minimum Data Set (a resident assessment tool), was mentally intact. On 01/08/2025 at 9:55 AM, Resident #22 was interviewed and stated that they did not know what papers were signed at the time they were admitted but that their family member, who was visiting, was aware. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/2025 at 9:57 AM, the resident's family member was interviewed and stated that they signed the Admission Agreement but that it was not explained to them. The family member stated, I would know about arbitration because I used to work in the public schools and I was part of the union. I has to do with dispute resolution, but I don't know exactly what it means. The family member stated that they were not told on admission that they had the right to refuse to sign or that if they signed the Arbitration Agreement, they were relinquishing the right to an attorney, and stated, They just told me to sign and I signed. The resident's Admission Agreement had been marked 'signed' but no signature was observed on the copy. Resident #206 was admitted to the facility on [DATE] with a Minimum Data Set documenting that the resident was mentally intact. On 01/08/2025 at 10:02 AM, Resident #206 was interviewed and stated, I remember signing that paper, but I don't know what it said, they didn't talk to me about it. I thought I had to sign or I would have to go back to the hospital, so I signed. The resident's Admission Agreement had been initialed by the resident. Resident #57 was admitted to the facility on [DATE] and was documented on their Minimum Data Set as moderately cognitively impaired. On 01/08/2025 at 10:04 AM, Resident #57 was interviewed and stated, I never sign anything, I won't do it. They wanted me to sign but I wouldn't. I am visually impaired and if I can't read it, I won't sign it. But they didn't even tell me what it was about. The facility submitted a statement that the resident refused to sign and their representative, who had not been present on admission, had also refused. On 01/08/2024 at 10:27 AM, the Administrator was interviewed and stated that the facility has never had any arbitrations. The Administrator stated that the Admission Agreement should be explained to the resident or their representative and that they should be given the opportunity to ask any questions. They should be referred to corporate finance only if there are questions that Admissions is unable to answer. The Administrator stated that the Agreement should be explained in its entirety including the Arbitration Agreement and that they would meet with Admissions to emphasize the need to explain it in simple language, not in legalese. 10 NYCRR 415.26

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48711 Based on record review and interview conducted during the Recertification Survey from 1/2/2025 to 1/8/2025, the facility did not ensure that the Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) committee consisted at a minimum of the Medical Director, or their designee attended 4 quarterly meetings. Specificially, the Medical Director has not participated in Quality Assurance & Performance Improvement (QAPI) and Quality Assessment & Assurance (QAA) meetings for 2 out of the 4 meetings as required. The findings: The policy and procedure entitled Quality Assurance and Performance Improvement dated 08/15 documented Quality Assurance Performance Improvement shall have a committee consisting of, at a minimum, of Executive Director/Administrator, Director of Nursing, Medical Director, Quality Coordinator/Director, and Compliance Director. Each facility shall meet at least quarterly. Review of the Monthly Meeting Attendance Sheets entitled Quality Assurance and Assessment Committee revealed the Medical Director did not sign the attendance sheet for the following Quality Assurance & Performance Improvement meetings on 1/31/2024, 2/16/2024, 3/27/2024, 4/18/2024, June 20, 2024, 07/25/2024, 08/15/2024, 09/19/2024, 10/18/2024. Clinical Assistant attended the meeting in place of Medical Director on 5/16/2024 and 12/19/2024. There is no documented evidence that the Medical Director attended the Quality Assurance & Performance Improvement meeting via Microsoft teams or in person for 2 out the 4 quarterly meetings. On 01/08/25 at 11:14 AM interview with the Attending Physician stated has been working at the facility since 2020 and has not attended any Quality Assurance & Performance Improvement meetings. On 01/08/25 at 11:51 AM interview with the Medical Director stated they attend the Quality Assurance & Performance Improvement meetings monthly, however, does always attend in person. Gets invited via email and attends via Microsoft teams. If cannot attend the meeting, the Clinical Assistant will stand in their place. The Attending Physician does not attend the Quality Assurance & Performance Improvement meetings. On 01/08/25 at 12:23 PM interview with the Administrator stated that the Quality Assurance & Performance Improvement meetings are held monthly and that the Medical Director gets invited via email. The meetings are also held in person, by telephone and via Microsoft teams. The Clinical Assistant to the Medical Director will attend the meetings if the Medical Director cannot attend. The Attending Physician has not attended the meetings. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/10/2025 at 3:00 PM an interview with the Clinical Assistant who stated that their role as a Clinical Assistant is more of an Administrative Role. They input documents into the electronic Medical Record, does not give medications, provide care, or medical assistive care to the Medical Director. The Clinical Assistant stated they attend Quality Assurance & Performance Improvement meetings when the Medical Director cannot attend, which is not that many. The Clinical Assistant stated that they do not attend the Quality Assurance & Performance Improvement meetings as much and is not that familiar with the facility's policies, procedures, and practices. 10 NYCRR 415.15(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observations, record review, and interviews conducted during the Recertification Survey from [DATE] to [DATE] the facility did not ensure that food was served in accordance with professional standards for food service safety to prevent foodborne illness and ensure that infection control practices were maintained. Specifically, a Certified Nursing Assistant #4 was observed assisting multiple residents with dining room in preparation for dining did not perform hand hygiene between residents. This was evident for 10 residents (of 23 total sampled residents for dining Resident # 7, #18, #19, #38, #39, #49, #52, #70, #72 and #87). (2) the facility did not ensure that disinfecting germicidal wipes, hand sanitizing solution was discarded by the manufacturer discharge date . This was evident for the infection control task. The findings are: The facility policy and procedure titled Uniform Dress Code revised ,d+[DATE] documented facial hair must be kept neatly trimmed, restrain all facial hair with heard net/restraint associates while working with food. The facility policy and procedure titled Hand Hygiene. Handwashing revised on [DATE], documented all personnel will perform hand hygiene appropriately in accordance with current standards of practice and Centers of Disease Control guidelines to prevent he transmission of organisms that cause infections. To reduce the risk of healthcare-associated infection by decreasing the risk of transmission of pathogenic microorganisms to resident and the persons within the health are setting. The facility considers hand hygiene for the prevention of healthcare associated infections. When to employ before and after resident contact, before/after meals of handling food items, after removing gloves. The facility policy and procedure titled Purchasing, Stocking Inventory Control (re-Order Points Procedure was last reviewed /revised [DATE] documented the supply chain manager request that inventory supplies are ordered as they are needed (when reorder point is reached. In addition, The Central Purchasing Office has major input into the inventory control system for establishing reorder points and reorder quantities based on delivery lead times, quantity discount, contract purchases, promotional sales and institutions cash flows. The Central Purchasing in conjunction with the facility Supply Chain Manager is responsible. The policy does not state what specific inventory control measures systems are utilized for the facility purchasing, stocking inventory control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During an observation of dining on the 2nd floor on ,d+[DATE] from 1143 AM-1149 AM, Certified Nursing Assistant # 4 was observed assisting multiple residents in the 2nd floor dining room in preparation for dining. Certified Nursing Assistant # 4 with bare hands assisted Resident # 52 to clean their hands with a hand wipe, gave a hand wipe to Resident # 39, gave hand wipe to Resident # 87 and assisted Resident # 38 to clean their hands. Certified Nursing Assistant #4 with bare hands assisted Resident #49 to clean their hands then gave a hand wipe to Resident # 19 and then assisted Resident # 7 to clean their hands. Certified Nursing Assistant #4 did not perform hand hygiene between residents. Certified Nursing Assistant # 4 then applied a glove on their left hand and cleaned the hands for Resident # 70 and wipe their hands and they gave a hand wipe to Resident #18 with left glove still on their on hand. Certified Nursing Assistant #4 did not perform hand hygiene between residents. Certified Nursing Assistant # 4 with the same glove on their left hand only cleaned Resident # 72 hands, and then cleaned Resident # 49 hands and then assisted Resident #38 to clean their hands. Certified Nursing Assistant #4 did not perform hand hygiene between residents. Certified Nursing Assistant # 4 then proceeded to wash their hands in the handwashing sink in the 2nd floor pantry area. During an interview on [DATE] at 11:50 AM, Certified Nursing Assistant # 4 was interviewed and stated that before and after a meal they clean their hands. They forgot to change gloves and had a new pair and then stated they did not change gloves between residents. Certified Nursing Assistant # 4 stated they needed to wash their hands to prevent cross contamination and for infection control. Further stated they should have sanitized or washed their hands when they take off gloves and put on a new pair. During an interview on [DATE] at 12:30 PM, the Registered Nurse # 2 was interviewed and stated that when they monitor the dining room at lunch time, they observe staff performing hand hygiene. Staff are supposed to clean their hands before assisting residents, before they touch resident's trays, in-between residents, when they feed residents, assisting a resident in finishing a task and sanitize hands between residents for infection control. During an interview on [DATE] at 11:43 AM, the Infection Preventionist was interviewed and stated they do rounds during the day when they come in to work Monday to Friday. They stated that they observe hand hygiene during meals ,d+[DATE] times a week. There were no concerns related to hand hygiene that they identified. Hand hygiene is an infection control practice to prevent cross contamination of food. Further stated they did staff inservice on hand hygiene in the last 3 months. 2. On [DATE] at 11:25 AM, in the medication room on the 2nd floor the hand sanitizer was observed to be expired with an expiration date of ,d+[DATE]. During an observation on [DATE] at 03:58 PM the 3rd floor pantry was observed and in the lower left cabinet facing the nurses station side there was and opened container of disinfecting wipes lot #112923C with expiration date of [DATE]. During an observation on [DATE] at 12:18 PM to 12:23 PM, the central supply room in the basement was observed and the following was found: antimicrobial skin cleanser antiseptic hand sanitizer at doorway by desk with expiration date of ,d+[DATE]. There were 3 sealed boxes with disinfecting wipes on the shelf containing germicidal wipes with 150 count sheets and each box contained 24 containers with lot numbers 112523 and 113023C with expiration date of [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335763	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Vincent Depaul Residence	900 Intervale Avenue Bronx, NY 10459

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:18 PM, the Central Supply Representative was interviewed and stated, that the units are provided supplies daily and as needed. They stated that they did not look at the date on the sanitizer and the wipes and as you can see the boxes were still sealed. The wipes that are expired are the old supply and we have new supply on the shelf. On [DATE] at 12:33 PM, the Infection Preventionist was interviewed and stated if expired hand sanitizer or disinfecting wipes supplies are used they won't be as effective. They stated that they have not looked at the sanitizing wipes, disinfecting wipes or hand sanitizer and that central supplies/housekeeping look at these supplies. On [DATE] at 12:06 PM and 1:01PM, the Director of Plant Operations and Maintenance was interviewed and stated, that the housekeeper changes sanitizer dispensers as needed once they are empty. If they need to be replaced such as if the sanitizer dispenser is not working then maintenance takes a look at the dispenser to see if they need to be replaced. The Central supply in the basement gives out germicidal wipes. Further stated that the central supply person is in charge of the supplies, and they look at it and they will check to see if the supplies are expired. 10 NYCRR 415.19(a)(1)(b)(4)

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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 - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Based on record review and interviews during the recertification survey conducted from 01/02/2025 to 01/08/2025, the facility did not ensure that each resident was offered the Pneumococcal immunization. This was observed in 3 of 5 residents (Residents #6, #84, #96) sampled for Immunizations out of a total of 23 sampled residents. Specifically, there was no documented evidence that Residents #6, #84, and #96 were offered or educated on the Pneumococcal immunization. The facility policy titled Resident Immunizations effective 05/2014 documented that all residents will receive immunizations as recommended by the Immunization Practices Advisory Committee (ACIP) of the U.S. Department of Health and Human Resources. The resident's status regarding the Pneumococcal vaccine will be obtained and documented in the electronic medical record. If needed, the resident will be offered the Pneumococcal vaccine unless the resident declines or previously received it. Each resident will receive a fact sheet about the vaccine. If the resident received the vaccine in another facility or in the community, an attempt will be made to obtain that information and it will be documented in the electronic medical record. If the resident refuses the vaccine, the reason for the refusal will be documented in the medical record. Findings include: Resident #6 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's Dementia, and Hemiplegia and Hemiparesis following Cerebral Infarction. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #6 had severe cognitive impairment. It also documented that Resident #6's Pneumococcal vaccination status was not up to date, with no reason documented for why the resident was not up to date on the Pneumococcal vaccination. Resident #84 was admitted to the facility on [DATE] and had diagnoses including Non-Alzheimer's Dementia and Type 2 Diabetes Mellitus. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #84 had severe cognitive impairment. It also documented that Resident #84's Pneumococcal vaccination status was not up to date, with no reason documented for why the resident was not up to date on the Pneumococcal vaccination. Resident #96 was admitted to the facility on [DATE] and had diagnoses including Zygomatic Fracture, Hypertension, and Muscle Weakness. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #96 was cognitively intact. It also documented that Resident #84's Pneumococcal vaccination status was not up to date, with no reason documented for why the resident was not up to date on the Pneumococcal vaccination. On 01/08/2025 at 11:03 AM, Resident #96 was interviewed and stated that they were educated on and received the Pneumococcal vaccine on 01/07/2025 but could not recall if they had been offered the vaccination prior to that. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/07/2025 at 11:06 AM, the Infection Preventionist was interviewed and stated that they had stepped into the Infection Preventionist role a few weeks ago after the facility's previous Infection Preventionist was unexpectedly no longer able to fill the position. They stated that the facility's policy was to offer the Pneumococcal vaccination to all residents on admission and annually after that if they declined on admission. The Infection Preventionist stated that after the surveyor requested resident Pneumococcal vaccination records on 01/06/2025, they realized that they did not have recent records reflecting that residents had been offered the vaccination so they immediately began to audit immunization records and offer the Pneumococcal vaccination to those who had not been offered it. The Infection Preventionist was unsure if the previous Infection Preventionist had been offering the vaccination to residents and was unable to produce documentation showing that it had been offered. On 01/08/25 at 10:58 AM, the Director of Nursing was interviewed and stated that the Infection Preventionist is responsible for ensuring residents receive immunizations. The Director of Nursing stated that they oversee the work done by the Infection Preventionist. They stated that the Infection Preventionist verified in the Citywide Immunization Record that it did not look like Residents #6, #84, and #96 had received the Pneumococcal vaccination, and they were unable to find documentation showing that it had been offered and declined. The Director of Nursing stated that the Pneumococcal vaccination should have been offered to these residents during admission and annually if they declined during admission, but based on the lack of documentation, it did not look like the residents had been offered the vaccination. They were unable to provide a reason for why this occurred. On 01/08/2025 at 11:14 AM, the Administrator was interviewed and stated that they believed that the lapse in the Pneumococcal vaccination being offered to residents was related to the unexpected change in staff members in the Infection Preventionist role. They stated that they believed that the previous Infection Preventionist may have been offering the vaccination to residents as per the facility's policy but they were unable to locate documentation reflecting that, because it was not in the electronic medical record. They stated that moving forward, the Infection Preventionist will ensure that residents' Pneumococcal immunization status is tracked and stored in the electronic medical record. 10NYCRR 415.19 (a) (1-3)