STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335792	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Manhattan Rehabilitation and Nursing Ctr	116 East 125th St New York, NY 10035

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services. Specifically, the facility reported short staffing on weekends confirmed by a review of the Daily Staffing and the Payroll Based Journal Staffing Data Report. The findings include:The facility's Payroll Based Journal Staffing Data Report for the 3rd quarter of Fiscal Year 2025 (04/01-06/30/3025) triggered low weekend staffing.The Facility assessment dated [DATE] stated the facility had an average of 310 occupied beds on 8 units with 40 beds on each floor. Par levels were listed as follows:Day shift, Units 2, 3, 5, 6 and 9 - 1 to 2 Registered Nurses / Licensed Practical Nurses and 3 to 5 Certified Nursing AssistantsDay shift, Units 4, 7 and 8 - 1 to 2 Registered Nurses / Licensed Practical Nurses and 4 to 6 Certified Nursing AssistantsEvening shift, Units 2, 3, 5, 6 and 9 -- 1 Registered Nurse / Licensed Practical Nurse and 2-4 Certified Nursing Assistants Evening shift, Units 4, 7 and 8 -- 1 Registered Nurse / Licensed Practical Nurse and 3-5 Certified Nursing Assistants Night shift, 1 Registered Nurse / Licensed Practical Nurse and 2 to 3 Certified Nursing Assistants on all units.The weekend staffing sheets were reviewed from 04/01/2025 to 06/30/3025 and showed the following: 1. On Saturday, 05/24/2025, the night shift nurse on Unit 4 called out and was not replaced. 2. On Saturday, 06/14/2025, Unit 3 had no nurse on the evening shift, and the evening supervisor filled in. 3. On Sunday, 06/15/2025, the night shift nurse on Unit 6 was off and was not replaced. 4. On Saturday, 06/21/2025, the night shift on Units 6 and 9 had one (1) Certified Nursing Assistant each. The Physician Order Activity Detail Reports for the quarter (04/01/2025 to 06/30/3025) revealed that 13 residents on Unit 6 required 2-person physical assist for toilet transfers, and 6 needed 2 assists for bed mobility; On unit 9, 12 residents needed 2 person assist for toilet transfers and 6 residents needed 2 assists for bed mobility.Staffing sheets for the week of 09/01/2025 to 09/07/2025 were also reviewed and revealed that on Monday, 09/01/2025, the night shift nurse on unit 3 called out and was not replaced. On Wednesday, 09/03/2025, there was only 1 Certified Nursing Assistant on the night shift in Unit 9. On Friday, 09/05/2025, the evening nurse on Unit 6 called out and was not replaced. On Sunday, 09/07/2025, Unit 6 had no assigned nurse on the day shift; the assigned nurse was off, and the 2nd nurse was floated to perform wound treatment on another floor. On 09/16/2025, during Resident Council meeting, Resident #182 stated they require 2 staff to get out of bed and sometimes staff get them out of bed by 2:00 PM. On 09/19/2025 at 1:50 PM, Certified Nursing Assistant #6 stated that sometimes it is a struggle especially when there are only 3 Certified Nursing Assistants. On 09/19/2025 at 9:08 AM, the Staffing Coordinator was interviewed and stated that they were not aware that there were shifts when the facility had not met its par levels. The Staffing Coordinator stated that when a unit is short of staff, they have a call list of nursing staff for replacement. They also stated that they come to work before 7:00 AM to address any last-minute callouts or no-shows, and that they are on call on weekends as well to help with staffing.On 09/19/2025 at 2:15 PM, the Director of Nursing was interviewed and stated that there are three (3) Certified Nursing Assistants in high acuity floors. If there are fewer than 3 aides, the night shift supervisor will float an aide from (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another floor. The Director of Nursing stated there was never just one (1) aide to give care on any floor on any shift. 10NYCRR414.13(a)(1) (i-iii)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide a summary of the baseline care plan for two (2) (Residents #5 and #98) of 40 sampled residents. Specifically, Resident #98 and Resident #5's representative were not provided with a written summary of the residents' baseline care plan. The findings include:The facility policy titled Baseline Care Plan with a last revised date of March 2025 documented that it is the policy of the facility to develop baseline care plan within 48 hours of admission. Along with the baseline care plan is a summary of care plan that is provided to the resident and or representative in a language that can be understood.1. Resident #98 was admitted with diagnoses that included Heart Failure and Peripheral Vascular Disease.The admission Minimum Data Set assessment dated [DATE] documented Resident #98's cognition as intact and that the resident participated in the assessment.On 09/15/2025 at 9:51 AM, Resident #98 was interviewed and stated they received a copy of their medication list but did not receive a written summary of their baseline care plan.Resident #98's baseline care plan was initiated on 05/19/2025 and was completed on 05/21/2025. There was no documented evidence that the summary was given to the resident or their representative. 2. Resident #5 was admitted to the facility with diagnoses that included Cerebrovascular Accident and Heart Failure.The admission Minimum Data Set assessment dated [DATE] documented Resident #5's cognition as moderately impaired and that Resident #5's family representative participated in the assessment. Resident #5's baseline care plan was initiated on 08/08/2025 and was completed on 08/10/2025. There was no documented evidence that the summary was given to the resident's representative.On 09/15/2025 at 11:00 AM, Resident #5's representative was interviewed and stated they have not received a written summary of Resident #5's baseline care plan.On 09/18/2025 at 11:20 AM, Social Worker #2 was interviewed and stated that the resident's baseline care plan is completed 48 hours from admission. They stated they do not provide a written summary of the baseline care plan to the resident, and that it is the Minimum Data Set nurse who is responsible for giving the resident or their representative a written copy of the baseline care plan. On 09/18/2025 at 11:30 AM, the Minimum Data Set Assessor was interviewed and stated that the baseline care plan is completed within 48 hours of admission and is given to the resident along with the medication list. The Assessor stated they do not remember giving the residents or their representative a copy of their baseline care plan. On 09/19/2025 at 10:29 AM, the Minimum Data Set Coordinator was interviewed and stated that the Minimum Data Set nurse is responsible for issuing the baseline care plan to the residents and must document when it was issued. They stated they are responsible for ensuring that the Baseline Care Plan is issued and documented. On 09/19/2025 at 9:30 AM, the Director of Nursing was interviewed and stated that the baseline care plan is supposed to be completed within 48 hours. They stated it is discussed with the resident , a copy given to the resident, and that the resident must sign indicating they received the summary of the baseline care plan. If the resident is not alert, a summary is given to the family, and the family must also sign that they received the copy. The Director stated that if the resident's family cannot come to the facility, then a copy of the baseline care plan is mailed and must be documented in the resident's progress notes. They stated the Minimum Data Set Nurse is responsible for providing the resident and / or their representative of the summary of the baseline care plan. 10 NYCRR 415.11(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure that residents are free of any significant medication errors. This was evident for one (1) (Resident #324) of 8 residents reviewed during the Medication Administration Task. Specifically, Resident #324 was not administered the 10:00 AM dose of Dorzolamide-Timolol eye drops as ordered by the physician and a 2:00 PM dose of Hydralazine 50 milligrams was held without physician notification.The findings include:The facility's policy and procedure titled Medication Administration, with a last revision date of 10/2024, documented medications are to be administered in a two-hour timeframe, one (1) hour before or after the medication order time. The nurse will review the Medication Administration Record for accuracy when all medication for a specific resident has been prepared. The nurse reviews each resident's medication as needed and notifies the physician if changes are needed.Resident #324 was admitted to the facility with active diagnoses that included Glaucoma and Hypertension.The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #324 had intact cognition. 1.) On 09/16/2025 at 12:03 PM, during medication administration observation with Licensed Practical Nurse #3 in Unit Five (5). Resident #324 reported to the surveyor that they had not been consistently receiving eye drops for glaucoma that are for scheduled for 10:00 AM. A physician's order dated 09/11/2025 documented to instill Dorzolamide 22.3 milligrams-Timolol 6.8 milligrams per milliliter one (1) drop in each eye two (2) times per day at 10:00 AM and 6:00 PM for ocular hypertension. A Care Plan Activity Report dated effective 02/07/2024, documented that Resident #324 had a sensory/visual deficit and received Dorzolamide and Latanoprost eye drops as ordered. A quarterly review note dated 07/24/2025 documented that Resident #324 continues Dorzolamide and Latanoprost eye drops as ordered.The Electronic Medication Administration Record for Resident #324 dated 09/16/2025, was reviewed with Licensed Practical Nurse #3. The 10:00 AM dose of Dorzolamide-Timolol eye drops was not signed off as given.On 09/16/2025 at 12:07 PM, an interview was conducted with Licensed Practical Nurse #3 who stated that when they administer medications, they review the electronic medication administration record for the resident's scheduled medications. Licensed Practical Nurse #3 stated they were confused by Resident #324 when they had questions about the eye drops so they did not administer the medication. Licensed Practical Nurse #3 further stated that they should have rechecked the medication administration record for accuracy and explained the medication dose and frequency to Resident #324, but they delayed instilling the eye drops and then forgot to go back and administer them. 2.) A physician's order dated 09/11/2025, documented Hydralazine 50 milligrams, give one (1) tablet three (3) times a day for Essential (Primary) Hypertension, scheduled at 10:00 AM, 2:00 PM, and 6:00 PM.A Care Plan Activity Report with an effective date of 02/07/2024, documented that Resident #324 had hypertension and was to be administered Hydralazine as ordered by the physician to maintain the blood pressure within normal limits. Abnormal findings should be promptly reported to the physician. On 09/17/2025 at 2:44 PM, a medication administration observation was performed with Licensed Practical Nurse #5 in Unit Nine (9) where Resident #324 had been transferred. Licensed Practical Nurse #5 reported that they will put on hold Resident #324's 50 milligram dose of Hydralazine that was scheduled for 2:00 PM because the resident's blood pressure was 119/53. Resident #324 was heard denying any complaints or signs/ symptoms of hypotension. Registered Nurse #2, the charge nurse was notified by Licensed Practical Nurse #5.On 09/18/2025 at 10AM, The Electronic Medication Administration Record dated 09/17/2025 was reviewed. The 09/17/2025 2:00 PM dose of Hydralazine 50 milligrams was not signed off as given. There was no documented evidence that the physician was notified. On 09/18/2025 at 3:13 PM, an interview was conducted with Registered Nurse #2, who was the charge nurse in Unit Nine (9), who stated that they were present on 09/17/2025 when Licensed Practical Nurse #5 held the 2:00 PM dose of Hydralazine for Resident #324. The Electronic Medical record was (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed with Registered Nurse #2. They stated that the Medication Administration Record for the 2:00 PM dose of Hydralazine was not signed off. Registered Nurse #2 also stated that Licensed Practical Nurse #3 should not have decided to omit a medication without calling the doctor and that they should have documented the details of the call. Registered Nurse #2 further stated that they should have followed up with Licensed Practical Nurse #5 to ensure the physician was notified and if not done, they should have called the physician. On 09/18/2025 at 3:50 PM, an interview was conducted with the Director of Nursing who stated that the physician must be called as soon as possible if a medication is held or omitted and that it is unacceptable that medications are omitted because the nurse forgot to give the medication. The Director of Nursing also stated that the documentation on the details of why the medication was omitted should be entered in the electronic medical record by the end of the shift.10 NYCRR 415.12 (m) (2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews , the facility did not ensure that drugs were stored in accordance with professional standards. This was evident in two (2) (Unit 3 and Unit 5) of nine (9) units observed for medication administration and medication storage. Specifically, Unit three (3) and Unit five (5) medication carts were left unlocked and unattended on 2 occasions. The findings include: The facility's policy and procedure titled Medication Administration, with a revision date of 10/2024, documented that it is preferable for the nurse to prepare medications from the Medication Administration Record at a medication cart, which is to be kept in close view of the nurse at all times and locked unless in use.On 09/16/2025 at 11:10 AM, Licensed Practical Nurse #3 left the medication cart unlocked in the hallway when they went to Resident #314's room to administer insulin. On 09/16/2025 at 11:55 AM, an interview was conducted with Licensed Practical Nurse #3 who stated that they forgot to lock the medication cart when they went to administer Resident #314's insulin. On 09/17/2025 at 1:00 PM, Licensed Practical Nurse #4 left the medication cart unlocked when they went to administer Resident #288's medication. A medication drawer that contained multiple blister packs of pills was observed left open in the corridor of room [ROOM NUMBER] which is located out of the view of the nurses' station.On 09/17/2025 at 1:10 PM, an interview was conducted with Licensed Practical Nurse #4 who stated that they always lock the medication cart and was not sure why they did not lock the cart when they went to administer the resident's medication. Licensed Practical Nurse #4 further stated that it is unsafe to leave the medication cart unlocked with the drawers open as someone could take the medications from the cart without their knowledge.On 09/16/2025 at 12:40 PM, an interview was conducted with the Director of Nursing who was observed on the floor with Licensed Practical Nurse #3. The Director of Nursing stated that nurses should lock the medication carts when they leave them in the hallway to go to a resident's room to administer medication. The Director of Nursing also stated that leaving medication carts open, unlocked, and unattended is a safety issue. A resident, especially those who wander, can take medications from unlocked medication art. 10 NYCRR 415.18(e)(1-4)

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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. Based on observation, record review, and interviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards of food service safety. This was evident during Dining and Kitchen Observation Task. Specifically, 1.) Certified Nursing Assistant #8 failed to perform hand hygiene while assisting residents with their meals. 2.) Kitchen staff were observed with visible facial hair while in the kitchen area. 3.) Expired food items were observed in the kitchen refrigerator. The findings include: 1.) The facility's Handwashing/Hand Hygiene policy with a last reviewed date of 02/2023 documented that the purpose of the procedure is to provide guidelines for effective handwashing and hygiene techniques to aide in the prevention of the transmission of infections. The policy stated that in most situations, the preferred method of hand hygiene is an alcohol-based hand rub, for instance, after contact with resident's skin and after removing gloves. During dining observation in Unit 9 on 09/17/2025 between 12:49 PM to 1:05 PM, Certified Nursing Assistant #8 was observed bringing Resident #183's lunch tray to the resident's room. The Certified Nursing Assistant then moved the remote control on the resident's bedside table, placed the resident's call bell with their reach, picked up the remote control after it dropped on the floor; and without performing hand hygiene, Certified Nursing Assistant #8 proceeded to opening the resident's soda can with bare hands and poured the soda into a cup. The Certified Nursing Assistant then opened the resident's sandwich with bare hands and placed the sandwich on the lunch tray. Without performing hand hygiene, Certified Nursing Assistant #8 then proceeded to assist Resident #122 with their electronic device and then took and placed Resident #173's lunch tray on the table. During an interview on 09/17/2025 at 1:07 PM, Certified Nursing Assistant #8 stated they were moving fast and only realized they did not perform hand hygiene when asked by the State Surveyor. During an interview on 09/18/2025 at 11:43 AM, the Director of Nursing stated they provided infection control training to the staff and that they conduct random unit observations, including dining observation, to track infection control practices. 2.) The facility's policy titled Facial Hair Restraint for Food Service Staff with an effective date of 09/2025 stated any employee who has visible facial hair must wear an approved beard guard while in food service/kitchen/preparation areas whenever they are handling food or coming in contact with surfaces or equipment that contact food. The restraint must cover the facial hair completely and be maintained in place during all food preparation, plating, and service tasks. During an observation on 09/14/2025 at 9:59 AM, the Food Service Manager was observed without facial restraint and with visible mustache, beard, and sideburns while in the kitchen area.During an interview on 09/14/2025 at 10:18 AM, the Food Service Director stated that they were rushing and did not grab a beard net. They stated they must wear beard net in the kitchen to prevent facial hair from falling on the food. During an observation on 09/16/2025 at 11:12AM, [NAME] #1 was observed in the tray line area with their mustache not properly covered. On 09/16/2025 at 11:29 AM, [NAME] #1 was interviewed and stated that their facial hair must be covered. 3.) The facility's policy titled Inventory and Rotation Policy with a reviewed date of 09/2025 documented that all food inventory must be rotated on a First In, First Out basis ensuring that food with an earlier expiration date is used first and eliminating waste due to spoilage. During an observation on 09/14/2025 between 9:59 AM to 10:27 AM, a container of potato salad with a best if used by date of 08/31/2025 and a box of skinless boneless turkey breast with a use or freeze by date of 06/13/2025 was observed in the refrigerator. During an interview on 09/14/2025 at 10:18 AM, the Director of Food Service stated they inspect the refrigerators on an ongoing basis and did not notice these expired items. 10 NYCRR 415.14 (h)