STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335819	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Extended Care Facility	425 National Boulevard Long Beach, NY 11561

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024 the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. This was identified for two (Resident #92 and Resident #87) of four residents reviewed for Dignity. Specifically, on 10/28/2024, Resident #92 and Resident #87, who resided in the same room, were observed in bed with multiple layers of linen, cloth chucks (pads used to protect the bed linen), and plastic liners. Additionally, both residents were wearing multiple briefs that were saturated with urine and the room had a strong urine odor. The findings are: The facility's policy and procedure for Resident Rights reviewed 1/2024 documented the facility to ensure all residents are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration, privacy in treatment and care for personal needs, and access to person and services inside and outside the facility. 1) Resident #92 was admitted to the facility with diagnoses that included Cerebrovascular Accident, Morbid Obesity, and Mood Disorder. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15, which indicated the resident had intact cognition. The resident required maximal assistance from staff for toileting, personal hygiene, lower body dressing, and transfers. The resident was always incontinent of bladder and bowel. The Resident Nursing Instructions dated 4/12/2024 documented the resident required extensive assistance for toileting, personal hygiene, and incontinent care was to be performed every two hours and as needed. The Comprehensive Care Plan for Activities of Daily Living dated 4/30/2024 and reviewed on 10/25/2024 documented to provide dressing, toileting, personal hygiene, and grooming as per the Certified Nursing Assistant Accountability Instructions. During an initial tour conducted on 10/28/2024 at 10:40 AM Resident #92 was observed in their room lying in bed. The room had a strong urine odor. The resident stated they had not seen their assigned Certified Nursing Assistant #9 since after breakfast. The resident stated they would like to be changed, dressed, and transferred out of bed. (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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(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	During an observation of care conducted on 10/28/2024 at 12:50 PM, Resident #92 was observed wearing three briefs. The briefs were saturated with urine and there was a strong urine odor in the resident's room. The resident's clothes, bed linen, and draw sheets were saturated with urine. After the completion of care, Resident #92 was transferred into a wheelchair. Certified Nursing Assistant #9 then removed the following items that the resident was lying on, from the resident's bed: two sets of draw sheets with a translucent sheet of plastic under each draw sheet, a blue chuck which was lying on top of two blankets and four additional blue chucks were observed under the blanket on top of the fitted sheet. 2) Resident #87 was admitted with diagnoses that included Dementia, Depression, and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, which indicated the resident had severely impaired cognition. The resident required supervision or touch assistance for toileting, and personal hygiene. The resident was always incontinent of bladder and was frequently incontinent of bowel. During an initial tour conducted on 10/2/24 at 10:51 AM, Resident #87 was observed in their room lying in bed. The resident responded appropriately to greetings. Resident #92, the roommate, stated Resident #87 was also waiting for care. During observation of care conducted on 10/28/2024 at 1:55 PM, Resident #87 was observed wearing two briefs. The brief closest to the resident's skin was observed to be yellow and saturated with urine. There was a strong urine odor in the room. The resident's bed was made with two sets of draw sheets and a blue chuck was placed under each draw sheet. A Comprehensive Care Plan for Incontinence dated 4/18/2024 and updated on 10/16/2024 documented to assist the resident with toileting, to keep the resident clean and dry, and to toilet on a regular schedule. The Resident Nursing Instructions dated 4/12/2024 documented the resident required one-person physical assistance for toileting and personal hygiene, and to toilet the resident every two to three hours and as needed. During an interview on 10/28/24 at 12:40 PM, Certified Nursing Assistant #9 stated they were not regularly assigned to Resident #92 and Resident #87; however, today they were assigned to both residents. Certified Nursing Assistant #9 stated they had not yet performed morning care for both residents. Certified Nursing Assistant #9 stated they were busy caring for the other residents on their assignment and Resident #92 and Resident #87 were the last residents on their assignment to receive the morning care. During an interview on 10/30/24 at 11:28 AM, Registered Nurse #1 stated the morning care should be completed by no later than 11:30 AM. Registered Nurse #1 stated they were not aware that the staff was putting multiple briefs on the residents and padding the residents' beds with plastic and multiple layers of linens and chucks. Registered Nurse #1 stated the resident's bed should have a fitted sheet, a single draw sheet, and a chuck. Registered Nurse #1 stated at no time should the residents be wearing multiple diapers. Registered Nurse #1 stated if a resident was a heavy wetter that the staff should change the resident more frequently. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 1:54 PM, the Director of Nursing Services stated they expect all the residents to receive their morning care by 11:00 AM. The nurses on the unit should be monitoring the Certified Nursing Assistants to ensure their assignments are completed. The Director of Nursing Services stated that the resident's bed should not have multiple layers of linens. The Director of Nursing Services stated there should be only one fitted sheet, a draw sheet, and a chuck on the resident's bed. The Director of Nursing Services stated at no time should the residents be wearing multiple briefs. During an additional interview on 11/4/2024 at 12:25 PM, Certified Nursing Assistant #9 stated they started their shift at 7:00 AM and went to Resident #92 and Resident #87's room to deliver breakfast. They did not check residents' briefs or the bed linen until 12:50 PM. Certified Nursing Assistant #9 stated they were on their way to provide care for Resident #92 and Resident #87 when they were asked by Registered Nurse #1 to monitor the dining room. Certified Nursing Assistant #9 stated they did not place the plastic, multiple linens, and chucks on the bed. Certified Nursing Assistant #9 further stated they did not place multiple briefs on the resident. During an interview on 11/4/2024 at 2:45 PM, the 11:00 PM-7:00 AM Certified Nursing Assistant #10 stated they changed Resident #92's brief at approximately 5:30 AM and before they ended their shift they checked and both residents were clean and dry. Certified Nursing Assistant #10 stated Resident #92 always asks for two briefs and gets upset if the staff does not provide them with two briefs. Certified Nursing Assistant #10 stated that they did put muliple briefs on the residents. 10 NYCRR 415.3(d)(1)(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on interviews and record review during the Recertification Survey and Abbreviated Survey (NY 00332218) initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure that services provided or arranged by the facility meet the current professional standards of quality This was identified for one (Resident #14) of two residents reviewed for Choices. Specifically, on 1/16/2024 the Physician ordered Diclofenac 0.1% (nonsteroidal anti-inflammatory) eye drops for 14 days Resident #14. The Diclofenac eye drops were not delivered by the pharmacy and were not available for administration until 1/24/2024; however, the nursing staff documented that the eye drops were administered to Resident #14 on 11 occasions between 1/16/2024 and 1/23/2024. The finding is: The facility's policy for Medication Administration and Documentation, last reviewed in April 2024 documented to ensure medication administration and documentation occurs in an accurate and timely manner. [Licensed nurses] should immediately notify the nursing supervisor if medication is unavailable for administration and ensure medication is delivered on the next delivery or when available. Notify the Physician if necessary and document missed doses. Document all held or refused medications on the Electronic Medication Administration Record and use prudent judgment by informing the Physician in a timely manner when medications are held, refused, or otherwise unavailable for administration. Resident #14 was admitted with diagnoses that included Dry Eye Syndrome, Obesity, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The resident had adequate vision with the use of corrective lenses. The Visual Function Comprehensive Care Plan dated 9/21/2021 last revised 9/20/2024 documented that the resident had Cataracts. Interventions included but were not limited to encouraging daily use of eyeglasses and monitor changes in visual functioning. A medical progress note dated 1/12/2024, written by Physician #2, documented Resident #14 had right eye Cataract surgery on 12/18/2023. On 1/10/2024, the resident was transferred to the emergency room STAT (immediately) for Ophthalmology evaluation after Resident #14 complained of right eye pain. Resident #14 was diagnosed with bacterial conjunctivitis in the emergency room . Physician #2 documented Resident #14 was seen status post right eye pain and was observed with mild redness in the right eye. The resident denied loss of vision. Physician #2 recommended a follow-up visit with Resident #14's Ophthalmologist. A Nursing Progress note dated 1/16/2024, written by Registered Nurse #11, documented Resident #14 returned from an ophthalmology visit with a recommendation to start Diclofenac 0.1% eye drop, one drop to the right eye for 14 days. A physician's order dated 1/16/2024 documented to administer Diclofenac 0.1% eye drops, instill one drop by ophthalmic (eye) route in the right eye 4 times per day for 14 days for Visual Discomfort in the Right Eye. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Pharmacy Clarification Request Form dated 1/17/2024 documented clarification is needed for Diclofenac 0.1% eye drop due to Resident #14's prior reaction to Aspirin. If the medication is new to the resident, the facility has to clarify allergies with the Physician and inform the pharmacy whether to discontinue the order or to dispense the medication. A Pharmacy packing delivery slip dated 1/24/2024 documented the Pharmacy delivered Resident #14's Diclofenac 0.1% solution on 1/24/2024 at 4:45 AM. During an interview on 11/01/2024 at 10:35 AM, Licensed Pharmacist #1 stated the pharmacy received an order for Diclofenac 0.1% eye drop for Resident #14 on 1/16/2024. Licensed Pharmacist #1 stated that the pharmacy did not dispense the eye drop until 1/23/2024 because clarification was needed for a possible allergic reaction to the eye drop due to the resident's documented allergy to Aspirin. A Review of Resident #14's Medication Administration Record dated January 2024 documented Diclofenac 0.1% one drop by ophthalmic (eye) route in the right eye 4 times a day for 14 days for visual discomfort in the right eye. The Medication Administration Record documented that on 11 occasions between 1/16/2024 and 1/23/2024, Diclofenac 0.1% eye drops were administered to Resident #14's right eye; and on 16 occasions between 1/16/2024 and 1/23/2024, the Medication Administration Record indicated that the eye drops were not administered to the resident due to unavailability of the medication. During an interview on 11/01/2024 at 2:10 PM, Licensed Practical Nurse #3, who documented administering Resident #14's Diclofenac 0.1% eye drops on 1/16/2024, stated they no longer worked at the facility and did not recall Resident #14. Licensed Practical Nurse #3 stated if a physician ordered medication was missing, they would have notified their supervisor and would not sign for what they did not administer. An interview with Registered Nurse #10, who documented administering Resident #14's Diclofenac eye drops on 1/18/2024, was attempted on 11/01/2024 at 10:01 AM and again at 11:04 AM. Registered Nurse #10 was unavailable for the interview. An interview with Licensed Practical Nurse #9, who documented administering Resident #14's Diclofenac eye drop on 1/19/2024 and 1/21/2024, was attempted on 11/01/2024 at 10:00 AM and again at 10:59 AM. Licensed Practical Nurse #9 was unavailable for an interview. During an interview on 11/01/2024 at 1:52 PM, the Medical Director stated nurses should notify their supervisor or the Physician if they noticed the physician-ordered medication was missing. The Medical Director further stated it was not acceptable to document medication was administered, when in fact the medication was not delivered by the Pharmacy and was not available for administration. During an interview on 11/04/2024 at 1:25 PM, the Director of Nursing Services stated that the medication nurses who had worked when Resident #14's Diclofenac 0.1% eye drop was unavailable should have reported and notified the Physician. The Director of Nursing Services stated that nurses cannot sign for medications that they did not administer. 10 NYCRR 415.11(c)(3)(i)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review, and staff interview during the Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024 the facility did not ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene. This was identified for two (Resident #92 and Resident #87) of three residents reviewed for activities of daily living. Specifically, 1) Resident #92 required staff assistance with activities of daily living care. During an observation on 10/28/2024, the resident did not receive their morning care until 12:50 PM. The resident stated they were wet and had not received care since the 11:00 PM-7:00 AM shift. 2) Resident #87 required staff assistance for the activity of daily living care. During an observation on 10/28/2024, the resident did not receive their morning care until 1:55 PM. The resident's brief was saturated with urine and the room had a strong urine odor. The findings are: The facility Activities of Daily Living (ADL) policy and procedure reviewed 2/2024 documented Activities of Daily Living care and support will be provided for residents who are unable to carry out Activities of Daily Living independently, with the consent of the resident ad in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that includes but not limited to supervision and assistance with hygiene (bathing, dressing, grooming) and elimination (toileting, incontinent care). 1) Resident #92 was admitted to the facility with diagnoses that included Cerebrovascular Accident, Morbid Obesity, and Mood Disorder. The Annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15, which indicated the resident had intact cognition. The resident required maximal assistance from staff for toileting, personal hygiene, lower body dressing, and transfers. The resident was always incontinent of bladder and bowel. The Resident Nursing Instructions dated 4/12/2024 documented the resident required extensive assistance for toileting, personal hygiene, and incontinent care was to be performed every two hours and as needed. The Comprehensive Care Plan for Activities of Daily Living dated 4/30/2024 and reviewed on 10/25/2024 documented to provide dressing, toileting, personal hygiene, and grooming as per the Certified Nursing Assistant Accountability Instructions. During an initial tour conducted on 10/28/2024 at 10:40 AM Resident #92 was observed in their room lying in bed. The room had a strong urine odor. The resident stated they had not seen their assigned Certified Nursing Assistant #9 since after breakfast. The resident stated they would like to be changed, dressed, and transferred out of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of care conducted on 10/28/2024 at 12:50 PM, Resident #92 was observed wearing three briefs. The briefs were saturated with urine and there was a strong urine odor in the resident's room. The resident's clothes, bed linen, and draw sheets were saturated with urine. After the completion of care, Resident #92 was transferred into a wheelchair. Certified Nursing Assistant #9 then removed the following items that the resident was lying on, from the resident's bed: two sets of draw sheets with a translucent sheet of plastic under each draw sheet, a blue chuck which was lying on top of two blankets and four additional blue chucks were observed under the blanket on top of the fitted sheet. 2) Resident #87 was admitted with diagnoses that included Dementia, Depression, and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, which indicated the resident had severely impaired cognition. The resident required supervision or touch assistance for toileting, and personal hygiene. The resident was always incontinent of bladder and was frequently incontinent of bowel. During an initial tour conducted on 10/2/24 at 10:51 AM, Resident #87 was observed in their room lying in bed. The resident responded appropriately to greetings. Resident #92, the roommate, stated Resident #87 was also waiting for care. During observation of care conducted on 10/28/2024 at 1:55 PM, Resident #87 was observed wearing two briefs. The brief closest to the resident's skin was observed to be yellow and saturated with urine. There was a strong urine odor in the room. The resident's bed was made with two sets of draw sheets and a blue chuck was placed under each draw sheet. A Comprehensive Care Plan for Incontinence dated 4/18/2024 and updated on 10/16/2024 documented to assist the resident with toileting, to keep the resident clean and dry, and to toilet on a regular schedule. The Resident Nursing Instructions dated 4/12/2024 documented the resident required one-person physical assistance for toileting and personal hygiene, and to toilet the resident every two to three hours and as needed. During an interview on 10/28/24 at 12:40 PM, Certified Nursing Assistant #9 stated they were not regularly assigned to Resident #92 and Resident #87; however, today they were assigned to both residents. Certified Nursing Assistant #9 stated they had not yet performed morning care for both residents. Certified Nursing Assistant #9 stated they were busy caring for the other residents on their assignment and Resident #92 and Resident #87 were the last residents on their assignment to receive the morning care. During an interview on 10/30/24 at 11:28 AM, Registered Nurse #1 stated the morning care should be completed by no later than 11:30 AM. Registered Nurse #1 stated they were not aware that the staff was putting multiple briefs on the residents and padding the residents' beds with plastic and multiple layers of linens and chucks. Registered Nurse #1 stated the resident's bed should have a fitted sheet, a single draw sheet, and a chuck. Registered Nurse #1 stated at no time should the residents be wearing multiple diapers. Registered Nurse #1 stated if a resident was a heavy wetter that the staff should change the resident more frequently. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 1:54 PM, the Director of Nursing Services stated when a Certified Nursing Assistant floats to a unit, the charge nurse is responsible for updating the Certified Nursing Assistants with any episodic medical concern, however, the specifics regarding the resident's care should be communicated by the Certified Nursing Assistants on the unit. The Director of Nursing Services stated they expect all the residents to receive their morning care by 11:00 AM. The nurses on the unit should be monitoring the Certified Nursing Assistants to ensure their assignments were completed. The Director of Nursing Services stated that the resident's bed should not have multiple layers of linens The Director of Nursing Services stated there should be only one fitted sheet, a draw sheet, and a chuck on the resident's bed. The Director of Nursing Services stated at no time should the residents be wearing multiple briefs and if the resident was a heavy wetter, then the staff should change the resident more frequently. During an additional interview on 11/4/2024 at 12:25 PM, Certified Nursing Assistant #9 stated they started their shift at 7:00 AM and went to Resident #92 and Resident #87's room to deliver breakfast. They did not check residents' briefs or the bed linen until 12:50 PM. Certified Nursing Assistant #9 stated they were on their way to provide care for Resident #92 and Resident #87 when they were asked by Registered Nurse #1 to monitor the dining room. Certified Nursing Assistant #9 stated they did not place the plastic, multiple linens, and chucks on the bed. Certified Nursing Assistant #9 further stated they did not place multiple briefs on the resident. During an interview on 11/4/2024 at 2:45 PM, the 11:00 PM-7:00 AM Certified Nursing Assistant #10 stated they changed Resident #92's brief at approximately 5:30 AM and before they ended their shift they checked and both residents were clean and dry. Certified Nursing Assistant #10 stated Resident #92 always asks for two briefs and gets upset if the staff does not provide them with two briefs. Certified Nursing Assistant #10 stated that they did put multiple briefs on the residents. 10 NYCRR 415.12(a)(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and interviews during the Recertification Survey and Extended Survey (NY 00331717), initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for two (Resident #156 and Resident #48) of four residents reviewed for Pressure Ulcers. Specifically, 1) Resident #156 entered the facility on 7/10/2024 with unstageable (the depth and stage of the wound cannot be determined until dead tissue is cleared away or removed and the base of the pressure injury is visible) pressure ulcers to their right and left heels; however, there was no documented evidence of treatment administration to the wound sites until 7/23/2024; and 2) wound care treatments for Resident #48's sacrum and buttock pressure ulcers were not administered as ordered by the Physician. The finding is: The facility's policy titled Pressure Ulcer Prevention and Wound Management, dated 12/2024, documented it is the policy of the facility to ensure that residents who have pressure ulcers receive the necessary treatments and services to promote the prevention of pressure ulcer decline, promote the healing of pressure ulcers, and prevent the development of additional pressure ulcers. The admitting licensed nurse will complete a comprehensive assessment of the resident, including total body and skin check on all admissions and readmissions, and record findings in the nursing admission documentation. Residents who are admitted or readmitted with pressure injuries will have appropriate treatment devices and wound orders obtained and implemented. 1) Resident #156 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Peripheral Vascular Disease, and Depression. The 7/14/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented that the resident had one Stage 4 pressure ulcer and two unstageable pressure ulcers. A review of the hospital discharge instructions dated 7/10/2024 documented that the resident had deep tissue injury to the sacrum/buttocks, bilateral lower extremity weeping edema (a condition where swelling becomes so severe that fluid leaks out of the skin), and unstageable pressure ulcers to bilateral heels. A review of the Nursing Admission Assessment, completed by Registered Nurse #7, dated 7/10/2024 documented the resident had a pressure ulcer to the lower back area/buttock area and wounds to the bilateral front of the lower leg areas. No wounds or pressure ulcers were identified on the heels. The nursing admission progress note, written by Registered Nurse #7, dated 7/10/2024 documented the resident had wounds to the sacrum, right buttock, and bilateral lower extremities. The admission physician's orders did not include treatment orders for the heel wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the July 2024 Treatment Administration Record revealed no documentation of treatment administration to the bilateral heel wounds until 7/23/2024. A nursing progress note dated 7/17/2024, written by Registered Nurse #6 (wound care nurse), documented skin assessment was attempted on 7/13/2024 for readmission assessment. The resident refused the assessment and complained of too many people assessing and repositioning the resident. The writer was able to visualize scattered openings to the lower extremities and swelling on bilateral feet. A review of the resident's medical record revealed no progress note written by Registered Nurse #6 on 7/13/2024. A medical progress note, written by a Podiatrist, dated 7/17/2024 documented the resident had a chronic right heel Stage 3 pressure ulcer measuring 5.0 centimeters in length, 5.0 centimeters in width, and 0.2 centimeters in depth with 80 % slough (dead tissue) and 20% granulation tissue; and chronic left heel Stage 3 pressure ulcer measuring 3.0 centimeters in length, 1.5 centimeters in depth and 0.2 centimeters in depth with 50 % slough and 50% granulation tissue. The treatment recommendations for both heels were to clean the wounds with Dakin's solution (a topical antiseptic that is used to treat and prevent infections in wounds), apply primary dressing, and cover with gauze. The care plan was discussed with the bedside staff, nurse, and wound care team. Physician orders dated 7/23/2024 for the right and left heel wounds, entered by Registered Nurse #6 (wound care nurse), documented cleanse with Dakin's solution and cover with Dakin's gauze followed by dry sterile dressing every day. A review of the July 2024 Treatment Administration Record revealed the treatments to the right and left heels were started on 7/23/2024. Comprehensive Care Plans effective 8/3/2024, titled Stage 3 right heel and Stage 3 left heel wounds, documented Resident #156 was seen by the Podiatrist on 7/17/2024 who recommended washing the wound with Dakin's solution. The Primary care physician agreed with the recommendations. During an interview on 10/31/2024 at 8:34 AM, Registered Nurse #6 (wound care) reviewed the nursing admission assessment and acknowledged the heel wounds for Resident #156 were not identified in the initial admission assessment. Registered Nurse #6 stated wound treatments should be started upon admission or when a wound is identified. Registered Nurse #6 stated they assess each newly admitted or readmitted resident's wounds on the following day after the admission; however they were not working on 7/11/2024 or 7/12/2024, therefore, they first saw Resident #156 on 7/13/2024 and the resident refused the assessment. Registered Nurse #6 did not know why no treatment orders were in place for the heel wounds until 7/23/2024. Multiple phone calls were made to interview Registered Nurse #7, the admission nurse, and messages were left to no avail. During an interview on 10/31/2024 at 11:39 AM, the Director of Nursing Services and Registered Nurse #6 stated that on 7/17/2024 during the Podiatrist's visit, the Podiatrist decided that the wound care would not be started that day because the resident was refusing care. On a subsequent visit by the Podiatrist on 7/21/2024, a decision was made by the podiatrist to start the wound care on 7/23/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Podiatrist and nursing notes dated 7/17/2024 and 7/21/2024 revealed no documentation related to postponing the recommended wound treatments. During an interview on 11/1/2024 at 1:28 PM, Physician #1 (the resident's Primary Care Physician and the Medical Director) stated they are usually notified of consultant recommendations by the nursing staff. Physician #1 stated they would never give orders to postpone a wound treatment. If there was a conversation with the Podiatrist about postponing pressure ulcer treatments, then the conversation should be documented in the resident's medical record and they expected to be notified. During an interview on 11/4/2024 at 1:40 PM, the Director of Nursing Services stated the admission nurse is expected to make sure wound orders are in place when wounds are identified upon admission and until the wound practitioner evaluates the wounds, treatment orders from the hospital should be followed or interim orders should be obtained. 2) Resident #48 was admitted with diagnoses including Paraplegia, Cancer, and Depression. The 9/2/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had three Stage 4 (involves full-thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers. Comprehensive Care Plans titled Left Buttock Stage 4, Right Buttock Stage 4, and Sacrum Stage 4 (pressure ulcers), all initiated on 11/27/2023 and last updated on 10/1/2024 documented that the resident had frequent behavior of refusing assessments by the wound Physician; however, there was no documented evidence that the resident refused actual treatment by the nursing staff. A review of the January 2024 Treatment Administration Records (based on the complaint NY 00331717 allegations) revealed the sacral, right buttock, and left buttock pressure ulcer treatments were not performed on 1/12/2024 and 1/14/2024. The treatments were scheduled for the 11:00 PM-7:00 AM shift. The documentation in the Treatment Administration Record documented that on 1/12/2024 the resident was sleeping and therefore the treatments were not performed. There was no documentation as to why the treatment was not done for 1/14/2024 A review of the September 2024 Treatment Administration Records (based on the complaint NY 00331717 allegations) revealed on 9/28/2024 and 9/30/2024 the sacral, right buttock, and left buttock pressure ulcer treatments were not performed. The treatments were scheduled for the 11:00 PM-7:00 AM shift. There was no documentation as to why the treatment was not administered on 9/28/2024. The Treatment Administration Record documented that on 9/30/2024 the resident refused the treatments. During an interview on 10/29/2024 at 11:14 AM, Registered Nurse #4 stated they worked on 1/12/2024 as the night shift supervisor and as the medication and treatment nurse on Resident #48's unit. Registered Nurse #4 stated the treatment was not provided to the resident on 1/12/2024 because the resident was asleep and they should write a progress note and let the next shift know that the treatment was not provided. Registered Nurse #4 stated when covering a unit and also covering the building as a shift Supervisor, sometimes they are called away to deal with emergencies and are not able to administer medications or do the treatments on the unit. A review of the medical record revealed no progress notes written by Registered Nurse #4 on 1/12/2024 related to wound treatment administration. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/29/2024 at 12:04 PM, Registered Nurse #3 (the Assistant Director of Nursing and the Risk Manager) stated they were assigned to Resident #48's unit as a nurse on 9/28/2024 and were responsible for administering medications and treatments because there were no other nurses to cover the unit. Registered Nurse #3 stated they probably forgot to sign for Resident #48's treatment administration and that lack of documentation meant the treatment was not done. During an interview on 10/29/2024 at 12:14 PM, Registered Nurse #5 (overnight supervisor who was also the assigned nurse to Resident #48's unit on 1/14/2024 and did not document on the treatment record that the treatments were completed) stated as a Supervisor, they usually have to cover a unit, it is impossible to be the supervisor and a floor nurse and do the regularly scheduled treatments on the unit. During an interview on 10/29/2024 at 12:29 PM, Registered Nurse #2 stated they were the assigned shift Supervisor on 9/30/2024 and had to cover Resident #48's unit to provide treatments and medication administration. Registered Nurse #2 stated they only worked at the facility for a week and did not recall doing wound care for Resident #48. Registered Nurse #2 stated they were very much behind in their work and did not think they completed their assigned work. During an interview on 10/31/2024 at 11:00 AM, Resident #48 stated they never refuse their wound care. The only thing they refuse is the assessment from the wound Doctor because the wound Doctor takes off the wound dressing that was already done and does not re-apply the dressing, just leaves, and the resident has to wait for a nurse to do the wound care. Resident #48 stated they prefer wound care treatments be completed on the 11:00 PM-7:00 AM shift because they do not want to wait for wound care during the day. During an interview on 11/4/2024 at 11:05 AM, the Administrator stated the Registered Nurse Supervisor is used as a last resort to cover a unit due to last-minute call-outs. The Registered Nurse Supervisor is instructed if there is an emergency, they attend to that and then go back to the regular duties for the unit. 10 NYCRR 415.12(c)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure that each resident maintained, to the extent possible, acceptable parameters of nutritional, and hydration status. This was identified for one (Resident #102) of one resident reviewed Dialysis. Specifically, Resident #102 had a physician's order for fluid restriction of 1200 milliliters per day. Resident #102's meal tickets and Electronic Medication Administration Record (EMAR) indicated the resident was receiving fluids that were exceeding the physician-ordered daily amount. The finding is: The facility's policy titled, Fluid Restrictions dated 3/2024, documented the facility provides fluid restrictions for residents placed on such restrictions per the discretion of the Physician. The unit dietitian will be responsible for initiating the physician's order for fluid restriction into the facility's computer system and will work with nursing to determine the amount of fluids that will be provided for the medication pass. The Dietitian, Nurse, and Physician will monitor the resident's status and make recommendations for changes in the fluid restriction as appropriate. Resident #102 was admitted with diagnoses including End Stage Renal Failure, Congestive Heart Failure, and Dependence on Renal Dialysis. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #102 had intact cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #102 was on a therapeutic diet (defined as a meal plan that controls the intake of certain food or nutrients) and received Dialysis. A Comprehensive Care Plan (CCP) titled Nutritional Status dated 10/9/2024 documented interventions that included small frequent snacks between meals, restricted fluid intake to 1200 milliliters per day, and provided supplements as ordered only one can per day. A physician's order dated 10/13/2024 and renewed on 10/29/2024 documented Fluid Restrictions of 1200 milliliters per day: fluids with medication administration of 420 milliliters (180 milliliters for the 7:00 AM-3:00 PM shift, 120 milliliters for the 3:00 PM-11:00 PM shift, and 120 milliliters for the 11:00 AM-7:00 PM shift); fluids with the meals 540 milliliters (300 milliliters for breakfast, 120 milliliters for lunch and 120 milliliters for dinner) and Nepro supplement: 240 milliliters daily. A review of the Electronic Medication Administration Record (EMAR) for October 2024 revealed the following; -On 10/18/2024 the resident received 240 milliliters of fluids on the 7:00 AM-3:00 PM shift and 240 milliliters of fluids on the 3:00 PM-11:00 PM shift for medication administration. The 11:00 PM-7:00 AM shift had no fluid amount documented as administered. The total amount of fluids administered on 10/18/2024 was 480 milliliters which was 60 milliliters more than the Physician's Ordered fluid amount during the medication pass. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 10/24/2024 the resident received 240 milliliters of fluids on the 7:00 AM-3:00 PM shift, 1200 milliliters on the 3:00 PM-11:00 PM shift, and 100 milliliters 11:00 PM-7:00 AM shift for medication administration. The total amount of fluids given for the medication administration on 10/24/2024 was 1540 milliliters which was 1120 milliliters more than the Physician's Ordered fluid amount during the medication pass. Resident #102 was observed on 10/30/2024 at 8:17 AM. Resident #102 was sitting in their wheelchair and eating their breakfast in their room. Resident #102's breakfast tray had two 120 milliliters of cranberry juice boxes and 180 milliliters of hot water in a cup. Resident #102's meal tickets for breakfast were reviewed for 10/30/2024 and 11/1/2024 which included two, 120 milliliters of cranberry juice and one 180 milliliters of hot water in a paper cup. Resident #102's fluid intake for breakfast was 420 milliliters (the resident was supposed to consume 300 millimeters of fluid during breakfast as per the physician's orders). Resident #102's fluid intake exceeded the fluid restrictions by 120 milliliters for breakfast. The Certified Nursing Assistant Accountability Sheet was reviewed on 10/30/2024 and indicated that the resident consumed 100 percent of their fluids during the breakfast meal. The Certified Nursing Assistant Accountability Sheet for fluid intake for breakfast was reviewed on 11/1/2024 and indicated that the resident consumed 100 percent of their fluids during the breakfast meal. Resident #102's meal tickets for lunch were reviewed for 10/30/2024 and 11/1/2024 which included 120 milliliters of cranberry juice and 180 milliliters of hot water in a paper cup. Resident #102's fluid intake for lunch was a total of 300 milliliters (the resident was supposed to consume 120 millimeters of fluid during the lunch meal as per the physician's orders). Resident #102's fluid intake exceeded the fluid restrictions for lunch by 180 milliliters. The Certified Nursing Assistant did not document the fluid intake for Resident #102 on 10/30/2024 and on 11/1/2024 for the lunch meal. Resident #102's meal tickets for dinner were reviewed for 10/30/2024 and 11/1/2024 which included 120 milliliters of cranberry juice. Resident #102's fluid intake for dinner was a total of 120 milliliters. The Certified Nursing Assistant Accountability Sheet for fluid Intake for dinner was reviewed on 10/30/24 and Certified Nursing Assistants documented that Resident #102 consumed 75 percent of their fluids. The Certified Nursing Assistant Accountability Sheet for fluid Intake for dinner was reviewed on 11/1/2024 and Certified Nursing Assistants documented that Resident #102 consumed 50 percent of their fluids. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Electronic Medication Administration Record (EMAR) revealed that on 11/2/2024 on the 7:00 AM-3:00 PM shift the resident received 100 milliliters of fluids; on the 3:00 PM-11:00 PM shift the resident received 240 milliliters of fluids; and on the 11:00 PM-7:00 PM shift the resident received 120 milliliters of fluids. The resident received a total of 460 milliliters of fluids on 11/2/2024 during the medication administration which was 40 milliliters more than ordered by the Physician. During an interview on 10/31/2024 at 10:45 AM, Certified Nursing Assistant #1 stated during breakfast Resident #102 had two boxes of cranberry juice. Certified Nursing Assistant #1 stated they documented the fluid consumption in percentage and not in the milliliter amount. Certified Nursing Assistant #1 stated they knew that the resident was on fluid restriction and the resident drank the fluids offered to them on the meal tray. During an interview on 11/1/2024 at 2:26 PM, the Food Service Director stated the Dietitian was responsible for all the resident's diets. The Food Service Director stated they were aware of the fluid restrictions for Resident #102, but they did not adjust the amount of fluids on the resident's meal tray as per the Physician's orders because the Dietitian was responsible for any changes in Resident #102's fluid restrictions. During an interview on 11/1/2024 at 3:28 PM, the Chief Clinical Dietitian stated they just started working at the facility and were still in the process of evaluating some of the residents. The Chief Clinical Dietitian stated they did not know there was an issue with Resident #102's fluid intake and that the resident was receiving extra fluids. The Chief Clinical Dietitian stated Resident #102 had a Physician Order for fluid restrictions that must be followed and if Resident #102 requested extra fluids or was non-compliant with the fluid restrictions, the Physician should have been notified. During an interview on 11/4/2024 at 1:36 PM, the Director of Nursing Services stated the meal tickets and Electronic Medication Administration Record (EMAR) for Resident #102 indicated that extra fluids were being given to Resident #102. The Director of Nursing Services stated the Physician's Order for fluid restrictions was very specific and should have been followed. The Director of Nursing Services stated the Certified Nursing Assistants documented fluid intake by percentage because that is how the electronic medical record system was set up to monitor the fluid intake during meals. 10 NYCRR 415.12(j)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews conducted during a Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure the Physician provided orders for the resident's immediate care and needs. This was identified for one (Resident #75) of two residents reviewed for Choices. Specifically, Resident #75 with a diagnosis of Epilepsy was receiving Topiramate (anticonvulsant medication) that should be gradually withdrawn to minimize the potential for seizures or increased seizure frequency as per the manufacturer's warning and precautions. The medication was abruptly stopped from 10/19/2024 to 10/22/2024 and restarted after four days on 10/23/2024. The finding is: The facility's policy and procedure titled Physicians Services last reviewed in March 2024 documented that the resident's medical care will be supervised by the attending Physician or alternate Physician who will assume the principal obligation and responsibility for managing the resident's medical care. On each visit, the Physician must review the resident's total program of care, including medications and treatments; write, sign, and date progress notes, sign and date all orders. The drug label from accessdata.fda.gov documented the warning and precautions: Withdrawal of Antiepileptic Drugs (AEDs) in patients with or without a history of seizures or epilepsy, antiepileptic drugs, including Topramax (Topiramate), should be gradually withdrawn to minimize the potential for seizures or increased seizure frequency. Resident #75 was admitted with diagnoses including Epilepsy and Epileptic Syndromes with Seizures, Migraine, and Major Depressive Disorder. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The Minimum Data Set documented the resident had a diagnosis of seizure disorder. Resident #75's History and Physician Admission assessment dated [DATE] documented that Resident #75 had a past medical history of Seizure Disorder and was admitted into the facility following hospitalization on account of a seizure with fracture of the right tibia (lower leg bone). The Physician documented a plan to continue Topiramate for Seizure Disorder. A physician's order dated 9/19/2024 documented to administer Topiramate 100 milligrams tablet (1 tablet) by oral route every 12 hours for 30 days for Epilepsy. There was no documented evidence that the Topiramate order was renewed after 30 days (on 10/19/2024). A Review of Resident #75's Medication Administration Record dated October 2024 indicated Resident #75 did not receive Topiramate 100 milligrams tablet on 10/19/2024, 10/20/2024, 10/21/2024 and 10/22/2024. A review of all progress notes from 10/18/2024 to 10/23/2024 was conducted. There was no documented evidence that a Physician assessed, evaluated, and ordered to discontinue Resident #75's Topiramate. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new physician's order dated 10/23/2024 documented to administer Topiramate 100 milligrams tablet (1 tablet) by oral route every 12 hours for Epilepsy. The Comprehensive Care Plan for Epilepsy dated 10/30/2024 documented the resident had a Seizure Disorder. Interventions included but were not limited to administering anti-seizure medications as per the physician's order and monitoring [resident] for seizure activity. During an interview on 10/28/2024 at 11:58 AM, Resident #75 stated they had Epilepsy and had been taking a steady dose of Topiramate (Topamax) and other antiseizure medication in the community. During an additional interview on 10/30/2024 at 1:26 PM, Resident #75 stated they were not aware of any changes in dosage and frequency of their Epilepsy medications. During an interview on 10/30/2024 at 3:45 PM, Physician #3 stated they worked together with Physician #1 and oversaw Resident #75's medical care. Physician #3 stated the Topiramate order from 9/19/2024 was automatically discontinued after 30 days; however, there was no plan to discontinue the use of Topiramate for Resident #14. Physician #3 stated they were not aware that Resident #75's Topiramate order was not renewed. During an interview on 11/1/2024 at 1:42 PM, Physician #1, who was Resident #75's Primary Care Physician and the Medical Director, stated that Resident #75 continued with the Epilepsy management per discharge instruction from the hospital and there was no plan or discussion to discontinue Topiramate medication. Physician #1 stated that Topiramate should be gradually reduced and should not be discontinued abruptly. Physician #1 stated if the antiseizure medication is abruptly stopped, the resident could experience seizure activity. Physician #1 stated the Physician should have renewed the Topriramate order to ensure the medication was not abruptly stopped and that Resident #75 continued to receive the medication. 10 NYCRR 415.15(b)(1)(i)(ii)

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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** 34798 Based on observations, record review, and interviews during the Recertification and Abbreviated Survey (NY 00331717) initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure it had sufficient nursing staff on a 24-hour basis to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on six of six resident units during the Sufficient Staffing Task. Specifically, 1) the Facility Assessment did not match the number actual number of Certified Nursing Assistants assigned to work on each unit; 2) medications during the 7:00 AM-3:00 PM shift were administered late on the 3rd and 5th floor nursing units due to understaffing issue; and 3) wound care was not performed on the 11:00 PM-7:00 AM shift for Resident #48 on multiple occasions because understaffing issue. Cross References: F 677 Quality of Life F 686 Quality of Care The finding is: The facility's policy titled Staffing Levels, dated 2/2024 documented the facility will attempt to maintain safe staffing levels at all times. Each department will assess staffing needs on a daily, shift-to-shift basis. The nursing department will arrange staff according to acuity and census to ensure the quality of care is maintained. All efforts will be made to ensure all slots are filled. In the event that a replacement cannot be obtained, efforts will be made to shift assignments and triage tasks. The nursing department will ensure each unit is maintained at safe staffing levels. This may require nursing to shift assignments to the unit with the highest acuity and/or highest census. Licensed nurses may be assigned to complete Certified Nursing Assistant responsibilities and administrative nurses may be assigned to administer medications and treatments. 1) The Facility assessment dated [DATE] documented the bed capacity is 240 residents and the average daily census is 225-240 residents. There are six resident units on floors 3 through 8 (Units 3, 4, 5, 6, 7, 8). Each unit has 40 beds. The Facility Assessment documented the facility does not take a census-based approach to staffing but looks at the acuity levels of the residents in order to provide the best staffing possible. The Administration team collaborates and reviews the staffing census daily. The goal of the facility is to ensure that all residents' needs are met in an appropriate and timely fashion. The Facility Assessment documented the following staffing plan: For the 7:00 AM-3:00 PM shift: -One Registered Nurse per unit except for Unit 8 (sub-acute unit), which required two Registered Nurses; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One Licensed Practical Nurse on each unit, with an exception for Unit 7 and Unit 8 (sub-acute units), which required two Licensed Practical Nurses each; - Four Certified Nursing Assistants for Unit 3 and Unit 5; five Certified Nursing Assistants for Unit 4 and Unit 7. -Unit 6 required 44 (an error in the Facility Assessment) Certified Nursing Assistants, -The Facility Assessment did not document the number of Certified Nursing Assistants needed for Unit 8. For the 3:00 PM-11:00 PM shift: -Two house Registered Nurses (Supervisor) for the shift. -There were no Registered Nurses assigned to the units; -One Licensed Practical Nurse for each unit, except for Unit 8, which required two Licensed Practical Nurses; -Four Certified Nursing Assistants for each unit, except for Unit 8, which required five Certified Nursing Assistants; For the 11:00 PM-7:00 AM shift: -One house Registered Nurse (Supervisor) for the shift. -There were no Registered Nurses assigned to the units; -One Licensed Practical Nurse for each unit; -Two Certified Nursing Assistants; A review of staffing sheets for weekends in July and August 2024 revealed the following: During the 7:00 AM to 3:00 PM Shift: -Unit 3 had three Certified Nursing Assistants assigned on 8/4/2024 and 8/25/2024. -Unit 5 had three Certified Nursing Assistants assigned on 7/7/2024, 7/21/2024, 8/3/2024, 8/4/2024, 8/18/2024, 8/24/2024 and 8/25/2024. The Facility Assessment indicated Unit 3 and Unit 5 needed four Certified Nursing Assistants. -Unit 4 had four Certified Nursing Assistants assigned on 7/7/2024, 7/14/2024, 7/20/2024 and 7/21/2024. -Unit 7 had three Certified Nursing Assistants assigned on 7/7/2024, 7/20/2024, and 8/24/2024. (continued on next page)

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Park Avenue Extended Care Facility	425 National Boulevard Long Beach, NY 11561

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Unit 7 had four Certified Nursing Assistants assigned on 7/6/2024, 7/13/2024 and 7/14/2024. The Facility Assessment indicated Unit 4 and 7 needed five Certified Nursing Assistants. -Unit 6 had three Certified Nursing Assistants assigned on 7/7/2024, 7/20/2024, 8/3/2024, and 8/18/2024. -Unit 6 had four Certified Nursing Assistants assigned on 7/21/2024. The Facility Assessment indicated Unit 6 needed 44 Certified Nursing Assistants. -Unit 8 had three Certified Nursing Assistants assigned on 7/6/2024, 7/7/2024, 8/3/2024, and 8/25/2024. -Unit 8 had four Certified Nursing Assistants assigned on 7/14/2024. The Facility Assessment did not document the number of Certified Nursing Assistants needed for Unit 8. During the 3:00 PM to 11:00 PM Shift: -Unit 3 had three Certified Nursing Assistants assigned on 7/6/2024. -Unit 4 had three Certified Nursing Assistants assigned on 7/6/2024, 7/28/2024, and 8/3/2024. -Unit 5 had three Certified Nursing Assistants assigned on 7/7/2024, 8/10/2024, 8/18/2024, and 8/24/2024. -Unit 7 had three Certified Nursing Assistants assigned on 7/13/2024, 7/21/2024, 7/27/2024 and 8/10/2024. -Unit 8 had three Certified Nursing Assistants assigned on 7/21/2024 and 8/10/2024. -Unit 8 had four Certified Nursing Assistants assigned on 7/6/2024, 7/7/2024, 7/13/2024, 7/14/2024, 7/21/2024, 7/27/2024 and 8/10/2024. The Facility Assessment documented four Certified Nursing Assistants for each unit, except for Unit 8, which required five Certified Nursing Assistants. During an interview on 10/31/2024 at 12:05 PM, Staffing Coordinator #1 stated the Director of Nursing Services and the Administrator make decisions on how many staff are needed daily for each shift. Staffing Coordinator #1 stated they are not familiar with the Facility Assessment. The number of Certified Nursing Assistants assigned to a unit varies day by day. The Staffing Coordinator discusses staffing needs with the Director of Nursing Services and the Administrator a day before the schedule is made. The Registered Nurse Supervisor is assigned to administer medications and treatments if the scheduled nurses call out or the facility cannot get another nurse to cover. The facility needs more Certified Nursing Assistants and nurses because it is a problem trying to cover staffing needs on all the shifts. Sundays are more difficult. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/2024 at 11:05 AM, the Administrator stated a few months ago staff had to work extra shifts to cover staffing needs because the facility was short-staffed. It was difficult to find staff, particularly on the weekends. The Administrator and Director of Nursing Services stated they review the acuity of the units and determine the staffing needs. The Administrator stated there are no staffing par levels as the staffing need is determined by the acuity level of the unit and not by census. The Administrator and Director of Nursing Services stated acuity changes based on how many residents may need a mechanical lift transfer, if there are behavioral problems, and how many residents are fall risks, and this can change daily. The Administrator stated there is an average of 4-5 Certified Nursing Assistants assigned to each unit. The Director of Nursing Services stated one medication nurse is sufficient to administer medications for 40 residents. The Administrator stated the Registered Nurse Supervisor working as a medication and treatment nurse on a unit is used as the last resort to cover the last-minute staff callouts. 2) On 10/28/2024 at 10:35 AM, Licensed Practical Nurse #4 was observed administering medications on the 5th floor nursing unit. The 5th floor nursing unit assignment sheet dated 10/28/2024 documented one Licensed Practical Nurse medication nurse, one Registered Nurse Supervisor, and five Certified Nursing Assistants assigned to the unit. During an interview on 10/28/2024 at 10:37 AM, Licensed Practical Nurse #4 stated they still had to provide the 9:00 AM medications to four residents (Resident #498, #499, #173, and #107). Licensed Practical Nurse #4 stated medication administration is late because they have to administer medication to 35-36 residents and address concerns brought up by other staff and residents. -On 10/28/2024 at 10:40 AM, Licensed Practical Nurse #2 was observed administering medications on the 3rd floor nursing unit. The 3rd floor nursing unit assignment sheet dated 10/28/2024 documented one Licensed Practical Nurse medication nurse, one Registered Nurse Supervisor, and five Certified Nursing Assistants assigned to the unit. During an interview on 10/28/2024 at 10:42 AM, Licensed Practical Nurse #2 stated they just started administering the 9:00 AM medications for the residents on the high side of the unit and still had 19 other residents who did not get their 9:00 AM medications. During an interview on 10/28/2024 at 11:13 AM, Registered Nurse #8 (the 3rd-floor unit supervisor) stated this was the first time they saw Licensed Practical Nurse #2 on the unit. The regularly assigned medication nurse was off today who can manage the medication administration times better. Registered Nurse #8 stated if Licensed Practical Nurse #2 had asked them for help with the medication administration they would have helped. During an interview on 10/29/2024 at 9:00 AM, Registered Nurse #9 (the 5th-floor supervisor) stated Licensed Practical Nurse #4 arrived on the unit at 8:30 AM and started the medication pass late on 10/28/2024. The medications that are scheduled for administration at 9:00 AM should be administered between 8:00 AM-10:00 AM. Registered Nurse #9 stated they should have started the medication pass themselves. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an additional interview on 10/30/2024 at 10:00 AM, Licensed Practical Nurse #2 stated they were assigned to the 3rd floor on 10/28/2024 for the first time and were not familiar with the residents on the unit. Licensed Practical Nurse #2 stated they did not ask for help. During an interview on 10/30/2024 at 1:36 PM, the Director of Nursing Services stated medications should be administered no earlier than one hour before and no later than one hour after they are scheduled. 3) Resident #48 was admitted with diagnoses including Paraplegia, Cancer, and Depression. The 9/2/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had three Stage 4 (involves full-thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers. Comprehensive Care Plans titled Left Buttock Stage 4, Right Buttock Stage 4, and Sacrum Stage 4 (pressure ulcers), all initiated on 11/27/2023 and last updated on 10/1/2024 documented that the resident had frequent behavior of refusing assessments by the wound Physician; however, there was no documented evidence that the resident refused actual treatment by the nursing staff. A review of the January 2024 Treatment Administration Records (based on the complaint NY 00331717 allegations) revealed the sacral, right buttock, and left buttock pressure ulcer treatments were not performed on 1/12/2024 and 1/14/2024. The treatments were scheduled for the 11:00 PM-7:00 AM shift. Registered Nurse #4 documented in the Treatment Administration Record on 1/12/2024 that the resident was sleeping and therefore the treatments were not performed. There was no documentation as to why the treatment was not done for 1/14/2024. A review of the September 2024 Treatment Administration Records (based on the complaint NY 00331717 allegations) revealed on 9/28/2024 and 9/30/2024 the sacral, right buttock, and left buttock pressure ulcer treatments were not performed. The treatments were scheduled for the 11:00 PM-7:00 AM shift. There was no documentation as to why the treatment was not administered on 9/28/2024. The Treatment Administration Record documented that on 9/30/2024 the resident refused the treatments. During an interview on 10/29/2024 at 11:14 AM, Registered Nurse #4 stated they worked on 1/12/2024 as the night shift supervisor and as the medication and treatment nurse on Resident #48's unit. Registered Nurse #4 documented the treatment was not provided to the resident on 1/12/2024 because the resident was asleep and they should write a progress note and let the next shift know that the treatment was not provided. Registered Nurse #4 stated when covering a unit and also covering the building as a shift Supervisor, sometimes they are called away to deal with emergencies and are not able to administer medications or do the treatments on the unit. A review of the staffing sheet dated 1/12/2024 indicated Registered Nurse #4 was the Nurse Supervisor for the 11:00 PM-7:00 Shift and covered Unit 8. The nurse assigned to Unit 3 did not have a checkmark in front of their name. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/2024 at 12:04 PM, Registered Nurse #3 (the Assistant Director of Nursing and the Risk Manager) stated they were assigned to Resident #48's unit as a nurse on 9/28/2024 and were responsible for administering medications and treatments because there were no other nurses to cover the unit. Registered Nurse #3 stated they probably forgot to sign for Resident #48's treatment administration and that lack of documentation meant the treatment was not done. During an interview on 10/29/2024 at 12:14 PM, Registered Nurse #5 (overnight supervisor who was also the assigned nurse to Resident #48's unit on 1/14/2024 and did not document on the treatment record that the treatments were completed) stated as a Supervisor, they usually have to cover a unit, it is impossible to be the supervisor and a floor nurse and do the regularly scheduled treatments on the unit. A review of the staffing sheet dated 1/14/2024 indicated Registered Nurse #5 was the Nurse Supervisor for the 11:00 PM-7:00 Shift and covered Unit 3. The nurse assigned to Unit 3 called out sick. During an interview on 10/29/2024 at 12:29 PM, Registered Nurse #2 stated they were the assigned shift Supervisor on 9/30/2024 and had to cover Resident #48's unit to provide treatments and medication administration. Registered Nurse #2 stated they only worked at the facility for a week and did not recall doing wound care for Resident #48. Registered Nurse #2 stated they were very much behind in their work and did not think they completed their assigned work. A review of the staffing sheet dated 9/30/2024 indicated Registered Nurse #2 was the Nurse Supervisor for the 11:00 PM-7:00 Shift and covered Unit 3 as the medication and treatment nurse. During an interview on 11/4/2024 at 11:05 AM, the Administrator stated the Registered Nurse Supervisor is used as a last resort to cover a unit due to last-minute call-outs. The Registered Nurse Supervisor is instructed if there is an emergency, they attend to that and then go back to the regular duties for the unit. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 34798 Based on observation and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024 the facility did not ensure that daily nursing staffing was posted in a prominent location and with the numbers of Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides who were working that day. Specifically, the facility lobby, near the front entrance, near the elevator bank, and the elevators were observed on 10/28/2024 at 8:55 AM and then again at 10:05 AM. There was no daily staffing posted that included the total number of licensed and unlicensed nursing staff working per shift. The finding is: During an observation on 10/28/2024 at 8:55 AM and again on 10/28/2024 at 10:05 AM, nursing staff posting was absent in the facility lobby and near the front entrance, near the elevator bank, in the elevators, and on the unit on the 8th floor. During an interview on 10/29/2024 at 1:30 PM, the Director of Nursing Services stated the Staffing Coordinator is expected to fill out and post the nursing staffing each morning and the Registered Nurse Supervisors for the shift would modify the sheet during their shift. The Director of Nursing Services stated they were not aware they had to post the staffing in public, prominent areas like the receptionist desk or elevator bank. The Director of Nursing Services stated the nursing staffing sheet is posted by the staff time clock and the vending machine area outside the Nursing Office. On 10/29/2024 at 1:35 PM the Director of Nursing Services showed the surveyor the nursing staff posting that was on the wall in an alcove outside the nursing office. The staff schedules were also located here. A review of the staff posting dated 10/29/2024 revealed the census for the 7:00 AM-3:00 PM shift and the categories of Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistant. For each category, the column number of staff documented 7.5. The total hours for each category were included in the adjacent column. The staff posting did not include the actual number of staff working per shift. During an observation on 10/30/2024 at 8:53 AM, the nursing staff posting was absent in the facility lobby, near the front entrance, near the elevator bank, and in the elevators. During an interview with the Administrator and the Director of Nursing Services on 11/4/2024 at 11:05 AM, the Administrator stated that the nursing staff posting used to be posted by the reception desk and a family member complained that there were too many postings at the front desk, so the facility moved the staff posting to the vending area. The Director of Nursing Services stated that the posting lists 7.5 in the number of staff column indicating the hours worked per shift by each staff member, not the actual number of staff members. The Administrator asked the surveyor if the number of staff should be documented rather than the 7.5 hours per staff member. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/4/2024 at 12:38 PM the Staffing Coordinator stated they filled out the staffing posting and gave it to the Director of Nursing Services daily. The Staffing Coordinator stated maybe the staff posting has to be revamped, and acknowledged the posting does not indicate the actual number of staff who worked. 10 NYCRR 415.13

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on interviews and record review during the Recertification Survey and Abbreviated Survey (NY 00332218) initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drug and biologicals) were provided to meet the needs of each resident. This was identified for one (Resident #14) of two residents reviewed for Choices. Specifically, Resident #14's Physician ordered Diclofenac 0.1% (nonsteroidal anti-inflammatory) eye drops for 14 days on 1/16/2024. The eye drop medication was not delivered to the facility by the Pharmacy until 1/24/2024. The finding is: The facility's Ordering and Obtaining Medication policy, last reviewed in August 2024, documented to verify with the attending Physician any dose or order that appears inappropriate considering the resident's age, condition, or diagnosis. The policy further documented to order drugs from the Pharmacy supplier after the order is clarified. Resident #14 was admitted with diagnoses that included Dry Eye Syndrome and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The resident had adequate vision with the use of corrective lenses. The Visual Function Comprehensive Care Plan dated 9/21/2021 last revised 9/20/2024 documented that the resident had Cataracts. Interventions included but were not limited to encouraging daily use of eyeglasses and monitor changes in visual functioning. The Allergy Comprehensive Care Plan dated 9/21/2021 last revised on 9/20/2024 documented that the resident was allergic to Aspirin (nonsteroidal anti-inflammatory drug) and Penicillamine (used for immunosuppression for Rheumatoid Arthritis). Interventions included but were not limited to notifying the Pharmacy of allergies and monitoring all medications to ensure that the resident did not ingest any related products. A Physician's progress note dated 12/15/2023, written by Physician #2, documented that Resident #14 was seen for medical clearance for Cataract surgery and was in optimal medical condition for the surgery. A medical progress note dated 1/12/2024, written by Physician #2, documented Resident #14 had right eye Cataract surgery on 12/18/2023. On 1/10/2024, the resident was transferred to the emergency room STAT (immediately) for Ophthalmology evaluation after Resident #14 complained of right eye pain. Resident #14 was diagnosed with bacterial conjunctivitis in the emergency room . Physician #2 documented Resident #14 was seen status post right eye pain and was observed with mild redness in the right eye. The resident denied loss of vision. Physician #2 recommended a follow-up visit with Resident #14's Ophthalmologist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress note dated 1/16/2024, written by Registered Nurse #11, documented Resident #14 returned from an ophthalmology visit with a recommendation to start Diclofenac 0.1% eye drop, one drop to the right eye for 14 days. A physician's order dated 1/16/2024 documented to administer Diclofenac 0.1% eye drops, instill one drop by ophthalmic (eye) route in the right eye 4 times per day for 14 days for Visual Discomfort in the Right Eye. A Pharmacy Clarification Request Form dated 1/17/2024 documented clarification is needed for Diclofenac 0. 1% eye drop due to Resident #14's prior reaction to Aspirin. If the medication is new to the resident, the facility has to clarify allergies with the Physician and inform the pharmacy whether to discontinue the order or to dispense the medication. A physician progress note dated 1/18/2024, written by Physician #2, documented Resident #14 returned from an ophthalmology visit on 1/16/2024 with a recommendation to start the Diclofenac 0.1% eye drops. There was no documented evidence that the Physician was made aware and addressed the Pharmacy's request to clarify the Diclofenac eye drop order. A review of Resident #14's Medication Administration Record for January 2024 documented that from 1/16/2024 to 1/23/2024, Resident #14 did not receive their Diclofenac 0.1% eye drops on 16 occasions; the medication was not available due to pending delivery from the Pharmacy. During an interview on 10/29/2024 at 11:17 AM, Resident #14 stated they had Cataract surgery on 12/18/2023 and were prescribed several different eye drops before and after their surgery. Sometimes these eye drops were not given to them. Resident #14 could not recall exactly when each eye drop was ordered and which eye drops were not administered. Resident #14 stated they would never refuse their eye drops. During an additional interview on 11/01/2024 at 11:53 AM, Resident #14 stated they were allergic to Aspirin and would experience a breakout reaction if they mistakenly ingested any. Resident #14 stated they reported pain and discomfort in their right eye after the Cataract surgery. Resident #14 did not recall if they received any eye drops for their eye discomfort. During an interview on 11/01/2024 at 10:35 AM, Licensed Pharmacist #1 stated the Pharmacy received an order for Diclofenac 0.1% eye drop for Resident #14 on 1/16/2024. The Pharmacy did not dispense the eye drop until 1/23/2024 because clarification was needed for a possible allergic reaction to the eye drop, as the resident had an Aspirin allergy. Licensed Pharmacist #1 stated that the Pharmacy would repeatedly call, fax, or communicate through inter-facility chat services to notify facilities if there were any issues with any medication orders. A Call was placed to the facility on [DATE] at 11:19 AM with no answer, then a fax was sent to the facility on [DATE] at 11:22 AM. Licensed Pharmacist #1 stated that medication would not be dispensed until medical clearance was obtained. Licensed Pharmacist #1 stated that the eye drop was delivered on 1/24/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 12:24 PM, Physician #2, who no longer worked at the facility, stated they did not recall being notified of the need to clarify the Diclofenac 0.1% eye drop order. Physician #2 stated they were not aware that the Diclofenac 0.1% eye drop was not available. Physician #2 stated they expected nursing staff to contact them and they (Physician #2) would have deferred to Resident #14's Ophthalmologist for clarification. Physician #2 stated that Diclofenac eye drop was typically prescribed for anti-inflammatory and pain relief purposes. During an interview on 11/01/2024 at 12:53 PM, Registered Nurse Supervisor #11 stated the nurse on the unit who received an inquiry from the Pharmacy regarding a medication order was responsible for contacting their supervisor or the Physician for clarification. Registered Nurse Supervisor #11 stated they did not recall if they received and responded to the Pharmacy's clarification request on 1/17/2024. Registered Nurse Supervisor #11 stated they did not know Diclofenac eye drop medication was unavailable for one week. Registered Nurse Supervisor #11 stated if they knew that the eye drops were missing, they would have notified the Physician and contacted the Pharmacy. During an interview on 11/01/2024 at 1:52 PM, the Medical Director stated they expected nurses to contact the Physician for clarification regarding the Pharmacy's inquiry to reduce delays in treatment. The Medical Director stated they expected any Pharmacy inquiries should be addressed no later than 12 hours so that medications can be delivered at the next possible delivery. The Medical Director stated that nurses should have notified their supervisor or the Physician that Resident #14's eye drops were unavailable. During an interview on 11/04/2024 at 1:25 PM, the Director of Nursing Service stated the nurse who received an inquiry from the Pharmacy for Resident #14's Diclofenac eye drop was responsible for informing the resident's Physician, obtaining the physician's order, and communicating the Physician's decision back to the pharmacy as soon as possible and document the actions taken. The Director of Nursing Services did not know the Pharmacy sent a clarification form to the facility to be completed. 10 NYCRR 415.18(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45349 Based on observation, interviews, and record review conducted during the Recertification Survey, initiated on 10/28/2024 and completed on 11/4/2024, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was evident during the Kitchen task observation. Specifically, frozen food items (pancakes, sausage patties, beef burger patties) were stored undated and with opened packaging. The finding is: The facility's policy titled Food Receiving and Storage, dated 12/2023, documented that Supervisors will observe all refrigerated and frozen goods for the integrity of the wrapping materials as a primary barrier to cross-contamination. The management team will ensure that all products are labeled and dated by the staff and utilized by their expiration date. Open dates are hand-written dates that will be placed on all opened kitchen stock products. Kitchen observation was conducted with the Food Service Director on 10/28/2024 at 9:31 AM. A walk-in freezer unit was observed with multiple open boxes of food with the inner plastic wrap also open, thereby exposing the food items to air. These items included three boxes of pancakes, one box of precooked sausage patties, and a box of beef patties. The observed open boxes were not dated to indicate when the boxes were first opened. The Food Service Director was interviewed on 11/04/2024 at 9:36 AM and stated that food packages in the freezer must be closed to prevent freezer burn and to reduce the possibility of cross-contamination. The Food Service Director stated that with freezer burn, the food quality diminishes and with cross-contamination, there is a possibility of illness. Additionally, there should be a date documented on the inner packaging to indicate when the boxes were first opened. 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
	335819	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Avenue Extended Care Facility	425 National Boulevard Long Beach, NY 11561

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/28/2024 and completed on 11/4/2024 the facility did not ensure call systems were accessible to each resident while the residents were in their rooms. This was identified for three (Resident #350, Resident #4, and Resident #87) of three residents reviewed for call systems. Specifically, 1) Resident #350, who was assessed to require assistance with transfer and locomotion, was observed in their room alone sitting in a chair; the call bell was observed on the floor approximately five feet away from the resident; 2) Resident #4, who was assessed to require staff assistance with transfers and locomotion, was observed on 10/28/2024 and 10/29/2024; the call bell was observed out of the resident's reach; and 3) Resident #87 was observed in bed on two occasions and the call bell was observed hanging from the wall onto the floor out of the resident's reach. The findings are: The facility's policy titled Call Bell and Alarm Response, dated 1/2024, documented the Certified Nursing Assistant will place the call bell within easy access for the resident. If a resident is unable to use or access the call bell, the Rehabilitation Department will assess the resident's fine motor skills and adjust/modify the call bell so that the resident may use it to communicate with the staff. These modifications may include a cord extension, a larger call bell, a handbell, or any other modifications that may meet the resident's needs. 1) Resident #350 was admitted with diagnoses including Alzheimer's Disease, Traumatic Subdural Hemorrhage (brain bleed), and a history of Falls. The 10/22/2024 Nursing Admission Assessment documented the resident was alert to self but not the place, time, or situation and needed assistance with transfers and locomotion. A Comprehensive Care Plan titled At Risk for Falls, effective 10/22/2024, documented an intervention for call bell within reach, answer promptly. Accident and Incident Reports dated 10/22/2024 and 10/24/2024 documented the resident had falls from bed. Preventive measures included the call bell being within reach. During an observation on 10/28/2024 at 10:16 AM, Resident #350 was in their room alone, sitting in a regular chair. The resident's wheelchair was observed in the room. The resident was awake but appeared confused. The call bell was on the floor about five feet from the resident. Certified Nursing Assistant #2 came into the room, checked on the resident, and left the room without placing the call bell within the resident's reach. During an interview on 10/28/2024 at 12:23 PM, Certified Nursing Assistant #2 stated the call bell should be accessible to the resident and they did not notice the resident's call bell was on the floor when they went in to check on the resident earlier in the morning. Certified Nursing Assistant #2 stated they placed the resident in the regular chair and did not place the call bell near the resident. Certified Nursing Assistant #2 stated it was unsafe for the resident to get up by themselves. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 at 11:34 AM, Registered Nurse #8 (unit supervisor) stated the call bell should have been accessible to Resident #350. During an interview on 10/30/2024 at 1:31 PM the Director of Nursing Services stated the call bell should have been accessible to the resident. 48827 2) Resident #4 was admitted with diagnoses including Cerebral Infarction, Hemiplegia, and Dementia. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, indicating Resident #4 had severely impaired cognition. The Minimum Data Set documented that Resident #4 was dependent (the helper does all the effort) for rolling left and right, sitting to lying, and lying to sitting on the side of the bed Resident #4 had impairment on one side of the lower extremity. The Comprehensive Care Plan titled At Risk for Falls dated 9/17/2024, documented interventions that included keeping the call bell within reach. Resident #4 was observed on 10/28/2024 at 9:30 AM sleeping in a Geri chair. The call bell was observed on the resident's bed and was out of the resident's reach. Resident #4 was again observed on 10/29/2024 at 8:18 AM lying in their bed. The call bell was observed hanging on the left side of the headboard and was out of the resident's reach. During an interview on 10/29/2024 at 9:18 AM, Certified Nursing Assistant #6 stated the call bell should be kept within reach for all residents. Resident #4 has a behavior of pushing their call bell away. All nursing staff are aware of the resident's behavior and frequently monitor the resident. A review of Resident #4's comprehensive care plan revealed no documented evidence that Resident #4 frequently pushed the call bell out of reach. During an interview on 10/30/2024 at 9:14 AM, Licensed Practical Nurse #6 stated Resident #4 has the behavior of pushing things away from themselves; however, did not know if the resident had a care plan for this behavior. Licensed Practical Nurse #6 could not recall if they notified the Nurse Supervisor of the resident's behavior of pushing the call bell away. During an interview on 10/30/2024 at 9:23 AM, Registered Nurse Supervisor #9 stated they were unaware of Resident #4's behavior of pushing the call bell away and this is the first time [they were] hearing this. Registered Nurse Supervisor #9 stated they would have put care plan interventions to address the behavior. Registered Nurse Supervisor #9 stated that the resident should have had their call bell within reach. During an interview on 10/30/2024 at 1:31 PM, the Director of Nursing Services stated the Nurse Supervisor should be made aware of the resident's behavior of pushing the call bell out. The Director of Nursing Services stated the call bell should be within reach of all residents. 28670 (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #87 was admitted to the facility with diagnoses that included Dementia, Depression, and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0 is the resident severely impaired in cognition (that section was not filled out). The resident had no functional limitation in range of motion to upper and lower extremities and required supervision or touch assistance for bed mobility and transfers. A Comprehensive Care Plan for Risk for Falls dated 10/7/2023 and updated 8/27/2024 documented to place the call bell within reach and answer promptly. During an initial tour conducted on 10/28/2024 at 10:51 AM, Resident #87 was observed awake in bed with their breakfast tray in front of them. The resident's call bell was observed hanging from the wall onto the floor and was out of the resident's reach. A second observation was made on 10/28/2024 at 12:45 PM. The resident was still in bed and the call bell was observed hanging from the wall onto the floor and was out of the resident's reach. During an interview on 10/30/2024 at 11:15 AM, Registered Nurse #1 stated the Certified Nursing Assistants and the nurses were responsible for ensuring the resident's call bell was within the resident's reach. Registered Nurse #1 stated the call bell should be placed within the resident's reach at all times. During an interview on 10/30/2024 at 1:29 PM, the Director of Nursing Services stated the resident's call bell should have not been on the floor. The Director of Nursing Service stated that the resident's call bell should be placed within the resident's reach at all times. 10 NYCRR 415.29