STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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 observation, interviews, and record review during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024 the facility did not ensure that each resident is treated with respect and dignity and cared for in a manner that promotes or enhances the resident's quality of life. Specifically, on two separate occasions, Resident #92 was observed in bed from the hallway with their urinary bag attached to the bed frame. The urinary bag had no privacy bag and was observed to contain urine. The finding is: The facility policy and procedure on Resident Privacy revised 4/2024 documented the goal of the policy is to ensure that all residents' right to privacy is respected and maintained in all aspects of care delivery and that all staff members respect the privacy and dignity of residents at all times. Resident #92 was admitted with diagnoses that included Hypertension, Renal Insufficiency, and Renal Failure. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15 which indicated intact cognition. The resident was dependent on staff for toileting and had an indwelling Foley catheter. A Comprehensive Care Plan dated 4/4/2024 documented the resident had a Foley Catheter secondary to Obstructive Uropathy and Chronic Kidney Disease. Interventions included to change the catheter as needed, and to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. A Physician's order dated 3/28/2024 documented to maintain a Foley catheter: size 16 French with the 10-centimeter balloon for diagnoses of Chronic Kidney Disease. Resident #92 was observed on 4/18/2024 at 11:00 AM in bed from the hallway. The resident's Foley drainage bag was observed hanging from the bed frame and was half filled with urine. There was no privacy bag in place. Resident #92 was observed on 4/18/2024 at 1:20 PM in bed from the hallway. The resident Foley drainage bag was observed hanging from the bed frame half filled with urine without a privacy bag in place. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #9 was interviewed immediately on 4/18/2024 at 1:20 PM and stated that they were assigned to Resident #92. Certified Nursing Assistant #9 stated that they provided care to the resident and knew that the resident's Foley bag did not have a privacy bag. Certified Nursing Assistant #9 stated that they should have asked the Registered Nurse in charge for a privacy bag. Registered Nurse #5 was interviewed on 4/18/2024 at 1:25 PM and stated that Certified Nursing Assistant #9 should have informed the medication nurse that they needed a privacy bag for Resident #92's Foley bag. Registered Nurse #5 stated that the resident's Foley drainage bag should have been covered with a privacy bag. The Director of Nursing Services was interviewed on 4/23/2024 at 2:24 PM and stated that during care the resident's Foley drainage bag did not need a privacy bag; however, after the care was provided Certified Nursing Assistant #9 should have ensured a privacy bag was in place to cover the Foley bag. The Director of Nursing Services stated that if the resident's Foley drainage bag was in full view from the hallway, then a privacy bag should have been in place. 10 NYCRR 415.3(d)(1)(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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on observations, interviews, and record review during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility did not ensure that the interdisciplinary team had determined that self-administration of medications was clinically appropriate for each resident. This was identified for one (Resident #186) of five residents reviewed for choices. Specifically, resident #186 was observed with multiple inhalers (Ventolin, Atrovent, Breo Ellipta) medications, on top of their room dresser. There was no documented assessment by the interdisciplinary team to determine if the resident could safely self-administer and store these medications in their room. The finding is: A facility policy and procedure titled, Medication: General Administration Guidelines last revised in October 2023, documented the facility maintains clinical records on all residents and assures that all Medication Administration Records note residents identifying information. Only physicians or licensed nurses may administer medication unless the resident is permitted to administer her/his own medications on the recommendation of the comprehensive care plan team and subsequent written order of the physician. Resident #186 was admitted with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, and Depression. A quarterly Minimum Data Set, dated dated dated [DATE] documented the resident's Brief Interview of Mental Status score was 14, indicating intact cognition. A quarterly Minimum Data Set, dated dated dated [DATE] documented the resident's Brief Interview of Mental Status score was 11, indicating moderately impaired cognition. Resident #186 required set-up assistance for eating and supervision for bed mobility and transfer. Resident #186 received antidepressant, hypnotic, anticoagulant, and diuretic medications. A current physician's order documented to administer Breo Ellipta Aerosol Powder Breath Activated 200-25 MCG/INH (Fluticasone Furoate-Vilanterol) 1 puff inhale orally one time a day at 0900 for Chronic Obstructive Pulmonary Disease, administered by Clinician. A current physician's order documented to administer Albuterol Sulfate hydrofluoroalkane. Inhalation Aerosol Solution 108 (90 Base) micrograms/activation, two puff inhale orally every 4 hours as needed for Chronic Obstructive Pulmonary Disease, administered by Clinician. A physician's order dated 4/25/2024, Ipratropium Bromide hydrofluoroalkane. Aerosol Solution 17 micrograms/activation, one puff inhale orally every 12 hours for Chronic Obstructive Pulmonary Disease, administered by Clinician. During an observation on 4/17/2024 at 10:57 AM Resident #186 was observed in their room. Three different inhalers (Ventolin, Atrovent, Breo Ellipta), were observed on the top of the resident's dresser. The observation, the resident stated that they use the medications by themselves. During an observation on 4/18/2024 at 11:58 AM, Resident #186 was observed in their room. Three different inhalers (Ventolin, Atrovent, Breo Ellipta), were observed on the top of the resident's dresser. The observation, the resident stated that they use the medications by themselves. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record lacked documented evidence of a physician's order for self-administration of medications including the inhalers. Licensed Practical Nurse #2 was interviewed on 4/18/2024 at 12:30 PM and stated that the doctor must write an order for the resident to self-administer medications. Licensed Practical Nurse #2 stated they did not know who had left the inhalers in the resident's room. When they were administering medication to Resident #186 this morning they observed using the inhalers. Licensed Practical Nurse #2 stated the nurse must ensure that the resident is oriented enough to self-administer the medication. Resident #182 only self-medicates inhalers. Registered Nurse Manager #2 was interviewed on 4/18/2024 at 12:35 PM and stated to self-medicate, there needs to be a physician's order and a care plan in place. Registered Nurse Manager #2 did not know what should be done if medication is observed in a room. Primary Care Physician #1 was interviewed on 4/26/2024 at 9:44 AM and stated the physician should assess the resident's ability to self-administer their medication. Primary Care Physician #1 was not sure if Resident #186 was assessed or not. Nurse Practitioner #2 was interviewed on 4/26/2024 at 10:06 AM and stated that they are not aware of any formal facility policy for a resident to self-administer medications. Nurse Practitioner # 2 stated for a resident to self-administer the medication the type of medication and the resident's ability to administer the medications has to be considered. 10 NYCRR 415.3 (f)(1) (vi)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on interviews and record review during a Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility failed to ensure that allegations of sexual abuse were reported to the Administrator or other officials immediately (or within two hours) after the allegations were made. This was identified for one (Resident #26) of seven residents reviewed for abuse. Specifically, on 3/30/2024 Resident #26, with intact cognition, reported to Licensed Practical Nurse #1 they were sexually abused by Certified Nursing Assistant #1. Licensed Practical Nurse #1 failed to report the allegations to the facility Administrator/designee or other officials. Resident #26 again reported the same allegation of sexual abuse to Certified Nursing Assistant #3 on 4/01/2024. Certified Nursing Assistant #3 informed Registered Nurse #1 of the allegation. Registered Nurse #1 failed to report the allegation to the facility Administrator/designee, or other officials. Certified Nursing Assistant #1 continued to be assigned to the same unit where Resident #26 resided and had access to the resident through 4/18/2024. This resulted in Immediate Jeopardy for Resident #26 with the potential for serious injury, serious harm, serious impairment, or death to 40 other residents who resided on Resident #26's unit. The finding is: The facility policy and procedure titled, Requirements for Reporting Suspected Case of Abuse, Neglect or Mistreatment, revised February 2024, documented mandatory reporters are required to report when they have a reasonable cause to believe that a person receiving care or services in a residential health care facility has been physically abused, mistreated, or neglected. When a suspicious incident occurs, it is the policy of this facility that the administrator and director of nursing or designee be made aware immediately by the staff reporting it. Employees are in-serviced on this policy upon hire, annually, and as needed to ensure compliance. The occurrence must be reported immediately to the Administrator, Director of Nursing Services, or designee, and to the New York State Department of Health but not later than 2 hours after the allegation is made. Resident #26 was admitted with diagnoses that included Major Depressive Disorder, Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and Anxiety Disorder. The annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14 which indicated intact cognition. The Minimum Data Set documented the resident had no behavioral or mood symptoms at the time of assessment. A Comprehensive Care Plan dated 4/18/2024, initiated after the allegation was brought to the facility's attention by the surveyor, documented the resident was at risk of being a victim due to dependence on caregivers for activities of daily living. The resident has a history of accusatory and physically abusive behaviors. Interventions included to assess the resident for signs and symptoms of abuse and or neglect and report to appropriate resources; investigate all allegations of abuse and neglect promptly; provide support and ensure the resident is free from abuse. During an initial tour on 4/18/2024 Resident #26 was interviewed at 1:15 PM. Resident #26 stated approximately two months ago Certified Nursing Assistant #1 inserted their finger into their vagina while providing care. Resident #26 stated they reported the incident to Licensed Practical Nurse #1. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Grievance Reports and Accident and Incident Reports for February 2024, March 2024, and April 2024 were reviewed on 4/19/2024. There was no documented evidence that a report was initiated for the allegation of sexual abuse made by Resident #26. During an interview on 4/18/2024 at 2:05 PM Certified Nursing Assistant #1 stated they worked at the facility as a part-time employee during the 7:00 AM - 3:00 PM shift. They usually covered Certified Nursing Assistant #3's assignment when Certified Nursing Assistant #3 was off. Certified Nursing Assistant #1 stated the assignment included providing care to Resident #26, who required two staff members for activities of daily living. Resident #26 was a two-staff approach (two staff required to interact with the resident) because the resident had accusatory behavior towards staff. Certified Nursing Assistant #1 stated on 3/31/2024 they provided daily care for Resident #26 including washing the resident's buttocks and perineal (genital) area. Certified Nursing Assistant #1 stated a second Certified Nursing Assistant was present during care. Certified Nursing Assistant #1 could not recall the name of the Certified Nursing Assistant who assisted them with Resident #26. Certified Nursing Assistant #1 stated when they returned to work on Tuesday (4/2/2024) they were told that Resident #26 had accused them of massaging their back, rubbing their buttocks, and sticking their finger in the resident's vagina (could not recall who notified them of the allegation). Certified Nursing Assistant #1 stated that at no time did their finger enter the resident's vagina. Certified Nursing Assistant #1 stated that even after the allegation was made, they were still assigned to provide care for Resident #26. Certified Nursing Assistant #1 stated they questioned Licensed Practical Nurse #1 as to why they were still assigned to Resident #26 after they were accused of sexual abuse. Certified Nursing Assistant #1 stated Licensed Practical Nurse #1 told them Resident #26 was a two-person approach and that Certified Nursing Assistant #1 had to care for the resident. A review of the Daily Assignment Sheets from 3/30/2024 to 4/18/2024 documented Certified Nursing Assistant #1 was assigned to Resident #26 on 3/30/24, 3/31/24, 4/2/24, 4/4/24, 4/11/2024, 4/13/2024, 4/14/2024, 4/16/2024 and 4/18/2024. During an interview with Registered Nurse #1 on 4/18/2024 at 4:06 PM they stated they were the Clinical Care Coordinator during the 7:00 AM - 3:00 PM shift on 4/1/2024. Registered Nurse #1 stated on 4/1/2024, Certified Nursing Assistant #3 reported to them, Resident #26 had made an allegation of sexual abuse against Certified Nursing Assistant #1. Registered Nurse #1 stated they went to speak with the resident and reminded the resident they had been accusatory towards the staff in the past. Registered Nurse #1 stated they did not assess the resident at the time but should have. Registered Nurse #1 stated they did not report the allegation to the administration and did not initiate an investigation because the resident told them they made up the allegation, as they wanted Certified Nursing Assistant #1 to be taken off their assignment. Registered Nurse #1 stated they were aware when an allegation of abuse is reported to them, they are responsible for initiating an investigation, interviewing the resident, and escalating as needed. Registered Nurse #1 stated they were supposed to report the allegation of abuse to the Director of Nursing and the Assistant Director of Nursing Services. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/19/2024 at 10:09 AM, Certified Nursing Assistant #3 stated they worked the 7:00 AM to 3:00 PM shift and were regularly assigned to Resident #26. Certified Nursing Assistant #3 stated they had no issues with Resident #26 and the resident was cooperative with care. Certified Nursing Assistant #3 stated approximately a month ago Resident #26 told them Certified Nursing Assistant #1 stuck their finger into their vagina. Certified Nursing Assistant#3 stated they did not recall the exact date the resident made the allegation. Certified Nursing Assistant #3 stated they reported this information to Licensed Practical Nurse #1 because Registered Nurse #1 was not available. Certified Nursing Assistant #3 stated they did not receive any instructions or updates from Licensed Practical Nurse #1 after they reported the allegation. Certified Nursing Assistant #3 stated approximately a week after they reported the allegation to Licensed Practical Nurse #1, the resident again reported the incident to Certified Nursing Assistant #3 on 4/1/2024. Certified Nursing Assistant #3 then reported the incident to Registered Nurse #1 on 4/1/2024. Registered Nurse #1 asked them to be a witness and to accompany Registered Nurse #1 to Resident #26's room when they spoke with Resident #26 because the resident was a two-person approach. Certified Nursing Assistant #3 stated Registered Nurse #1 asked Resident #26 if Certified Nursing Assistant #1 had stuck their finger into their (Resident #26's) vagina. Certified Nursing Assistant #3 stated the resident did not retract their allegation during the interview. Certified Nursing Assistant #3 stated they were in-serviced on abuse, and reporting, and knew to immediately report the allegation of sexual abuse to Registered Nurse #1. During an interview on 4/19/2024 at 9:39 AM, the Director of Nursing Services stated that Registered Nurse #1 did not notify them of the sexual abuse allegation made by Resident #26 until 4/18/2024 at approximately 2:30 PM. The Director of Nursing Services stated that once Registered Nurse #1 was made aware of the allegations, they were responsible for immediately notifying the Director of Nursing Services or the facility Administrator, and for initiating the investigation. The Director of Nursing Services stated that as soon as the allegation was made, Registered Nurse #1 should have assessed the resident and removed the alleged Certified Nursing Assistant #1 from the unit. The physician and the resident's designated representative should have been notified; statements from all staff involved, and any potential witnesses should have been obtained. The Director of Nursing Services stated Registered Nurse #1 should have also documented the assessment in the medical record and updated the resident's care plan regarding the allegation. During an interview on 4/19/2024 at 10:12 AM, the Administrator stated they were first made aware of Resident #26's allegation of sexual abuse on 4/18/2024 at 5:10 PM. The Administrator stated they expected the facility staff to notify them of any abuse allegations immediately after the resident first reported the occurrence. The Administrator stated that the resident should have been assessed for physical injuries, and psychological changes reflected in the resident's behavior, and the assessment should have been documented in the resident's medical record. The Administrator stated if they were notified of the allegations, they would have instructed staff to remove Certified Nursing Assistant #1 from the schedule immediately; ensured that an assessment was completed, the physician was notified, the resident was provided emotional support along with the psychological services and would have reported the incident to the New York State Department of Health. During an interview on 4/19/2024 at 12:35 PM, Licensed Practical Nurse #1 stated they were regularly assigned to Resident #26's unit during the 7:00 AM-3:00 PM. Licensed Practical Nurse #1 stated that no one reported any sexual abuse allegations to them. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2024 at 12:47 PM, the Medical Director stated that the Director of Nursing Services first made them aware of Resident #26's allegation of sexually inappropriate behavior by staff on 4/18/2024. The Medical Director stated that they expect inappropriate behaviors toward the residents should not occur; however, when the resident made such an allegation, the accused staff should have been removed from the daily schedule and the allegation should have been investigated and reported promptly. The Medical Director stated regardless of the resident's accusatory behavior, any allegation of abuse of any kind should be fully investigated. The Medical Director stated that residents who have accusatory behaviors are at higher risk for abuse because they are not taken seriously and can often be taken advantage of because of this behavior. The Medical Director stated Registered Nurse #1 should have reported the allegations of sexual abuse to the Director of Nursing Services, and it was not Registered Nurse #1's decision to decide not to investigate the allegation. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on interviews and record review during a Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility failed to ensure that all allegations of abuse, neglect, and mistreatment were thoroughly investigated. This was identified for one (Resident #26) of seven residents reviewed for abuse. Specifically, on 3/30/2024 Resident #26 reported to Licensed Practical Nurse #1 that they were sexually abused by Certified Nursing Assistant #1. There was no documented evidence Licensed Practical Nurse #1 took steps to initiate an investigation into the allegation. On 4/1/2024, Resident #26 reported the same allegation to Certified Nursing Assistant #3. Certified Nursing Assistant #3 informed Registered Nurse #1 of the allegation. There was no documented evidence Registered Nurse #1 took steps to initiate an investigation into the allegation. Through 4/18/2024, Certified Nursing Assistant #1 continued to be assigned to and worked on the same unit where Resident #26 resided. As of 4/18/2024, the facility had failed to provide documented evidence that it had conducted and completed a thorough investigation within 5 days of the allegations of sexual abuse. This resulted in Immediate Jeopardy for Resident #26, with the potential for serious injury, serious harm, serious impairment, or death to 40 other residents who resided on Resident #26's unit. The finding is: The facility Investigation Policy and Procedure on Resident Accidents and Incidents with a revision date of 4/2024, directed that within 24 hours of the reported incident or accident, the risk manager or nurse supervisor must complete the Resident Accident & Incident Summary Report to determine if there is reason to believe that abuse, neglect, mistreatment, or misappropriation has occurred, and to determine the underlying cause of the reported accident or incident. The facility has 2 hours to report abuse to the New York State Department of Health. The policy further documented to thoroughly investigate every accident/incident for potential abuse, neglect, mistreatment, or misappropriation. If there is a cause to believe abuse, neglect or mistreatment has occurred, or that an accident and incident meets the New York State Department of Health reporting requirements (injury of unknown origin, choking, burn, suicide attempt, care plan violation, etc.), the risk manager or reporting Registered Nurse must inform the Director of Nursing Services or the Administrator immediately. Any employee suspected of abuse, neglect, or mistreatment must immediately be removed from the work schedule pending the results of the investigation by facility administration. Resident #26 was admitted with diagnoses that included Major Depressive Disorder, Bipolar Disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and Anxiety Disorder. The annual Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14 which indicated intact cognition. The resident had no behavioral or mood symptoms at the time of assessment. A Comprehensive Care Plan dated 4/18/2024, initiated after the allegation was brought to the facility's attention by the surveyor, documented the resident was at risk of being a victim due to dependence on caregivers for activities of daily living. The resident has a history of accusatory and physically abusive behaviors. Interventions included to assess the resident for signs and symptoms of abuse and or neglect and report to appropriate resources; investigate all allegations of abuse and neglect promptly; provide support and ensure the resident is free from abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an initial tour on 4/18/2024, Resident #26 was interviewed at 1:15 PM. Resident #26 stated approximately two months ago Certified Nursing Assistant #1 inserted their finger into their (Resident #26's) vagina while providing care. Resident #26 stated they reported the incident to Licensed Practical Nurse #1. The facility's Grievance Reports and Accident and Incident Reports for February 2024, March 2024, and April 2024 were reviewed on 4/19/2024. There was no documented evidence that a report was initiated for the allegation of sexual abuse for Resident #26. There was no documented evidence that an investigation was initiated related to the sexual abuse allegation made by Resident #26. During an interview on 4/18/2024 at 2:05 PM, Certified Nursing Assistant #1 stated they worked at the facility as a part-time employee during the 7:00 AM - 3:00 PM shift. They usually covered Certified Nursing Assistant #3's assignment when Certified Nursing Assistant #3 was off. Certified Nursing Assistant #1 stated the assignment included providing care to Resident #26, who required two staff members for activities of daily living. Resident #26 was a two-staff approach (two staff required to interact with the resident) because the resident had accusatory behavior towards staff. Certified Nursing Assistant #1 stated on 3/31/2024 they provided daily care for Resident #26, including washing the resident's buttocks and perineal (genital) area. Certified Nursing Assistant #1 stated a second Certified Nursing Assistant was present during care. Certified Nursing Assistant #1 could not recall the name of the Certified Nursing Assistant who assisted them with Resident #26. Certified Nursing Assistant #1 stated when they returned to work on Tuesday (4/2/2024) they were told Resident #26 had accused them of massaging their back, rubbing their buttocks, and sticking their finger in the resident's vagina (could not recall who notified them of the allegation). Certified Nursing Assistant #1 stated that at no time did their finger enter the resident's vagina. Certified Nursing Assistant #1 stated that even after the allegation was made, they were still assigned to provide care for Resident #26. Certified Nursing Assistant #1 stated they questioned Licensed Practical Nurse #1 as to why they were still assigned to Resident #26 after they were accused of sexual abuse. Certified Nursing Assistant #1 stated Licensed Practical Nurse #1 told them Resident #26 was a two-person approach. and that Certified Nursing Assistant #1 had to care for the resident. During an interview with Registered Nurse #1 on 4/18/2024 at 4:06 PM, they stated they were the Clinical Care Coordinator during the 7:00 AM - 3:00 PM shift on 4/1/2024. Registered Nurse #1 stated on 4/1/2024 Certified Nursing Assistant #3 reported the resident had made an allegation of sexual abuse against Certified Nursing Assistant #1. Registered Nurse #1 stated they went to speak with the resident and reminded the resident they had been accusatory towards the staff in the past. Registered Nurse #1 stated they did not assess the resident at the time but should have. Registered Nurse #1 stated they did not report the allegation to the administration and did not initiate an investigation because the resident told them they (Resident #26) made up the allegation as they wanted Certified Nursing Assistant #1 to be taken off their assignment. Registered Nurse #1 stated they were aware that when an allegation of abuse is reported to them, they are responsible for initiating an investigation, interviewing the resident, and escalating as needed. Registered Nurse #1 stated they were supposed to report the allegation of abuse to the Director of Nursing and the Assistant Director of Nursing Services. (continued on next page)

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	335840	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/19/2024 at 10:09 AM, Certified Nursing Assistant #3 stated they worked the 7:00 AM to 3:00 PM shift and were regularly assigned to Resident #26. Certified Nursing Assistant #3 stated they had no issues with Resident #26 and the resident was cooperative with care. Certified Nursing Assistant #3 stated approximately a month ago Resident #26 told them that Certified Nursing Assistant #1 stuck their finger into their vagina. Certified Nursing Assistant#3 stated they did not recall the exact date the resident made the allegation. Certified Nursing Assistant #3 stated they reported this information to Licensed Practical Nurse #1 because Registered Nurse #1 was not available. Certified Nursing Assistant #3 stated they did not receive any instructions or updates from Licensed Practical Nurse #1 after they reported the allegation. Certified Nursing Assistant #3 stated approximately a week after they reported the allegation to Licensed Practical Nurse #1, the resident again reported the incident to Certified Nursing Assistant #3 on 4/1/2024. Certified Nursing Assistant #3 then reported the incident to Registered Nurse #1 on 4/1/2024. Registered Nurse #1 asked them (Certified Nursing Assistant #3) to be a witness and to accompany Registered Nurse #1 to Resident #26's room when they spoke with Resident #26 because the resident was a two-person approach. Certified Nursing Assistant #3 stated Registered Nurse #1 asked Resident #26 if Certified Nursing Assistant #1 had stuck their finger into their (Resident #26) vagina. Certified Nursing Assistant #3 stated the resident did not retract their allegation during the interview. Certified Nursing Assistant #3 stated that they were in-serviced on abuse and reporting and knew to immediately report the allegation of sexual abuse to Registered Nurse #1. During an interview on 4/19/2024 at 9:39 AM, the Director of Nursing Services stated that Registered Nurse #1 did not notify them of the sexual abuse allegation made by Resident #26 until 4/18/2024 at approximately 2:30 PM. The Director of Nursing Services stated that once Registered Nurse #1 was made aware of the allegations, they were responsible for immediately notifying them (Director of Nursing Services) or the facility Administrator and for initiating the investigation. The Director of Nursing Services stated that as soon as the allegation was made, Registered Nurse #1 should have assessed the resident and removed the alleged Certified Nursing Assistant #1 from the unit. The physician and the resident's designated representative should have been notified; statements from all staff involved, and any potential witnesses should have been obtained. The Director of Nursing Services stated Registered Nurse #1 should have also documented the assessment in the medical record and updated the resident's care plan regarding the allegation. During an interview on 4/19/2024 at 10:12 AM, the Administrator stated they were first made aware of Resident #26's allegation of sexual abuse on 4/18/2024 at 5:10 PM. The Administrator stated they expected the facility staff to notify them of any abuse allegations immediately after the resident first reported the occurrence. The Administrator stated that the resident should have been assessed for physical injuries, and psychological changes reflected in the resident's behavior, and the assessment should have been documented in the resident's medical record. The Administrator stated if they were notified of the allegations, they would have instructed staff to remove Certified Nursing Assistant #1 from the schedule immediately; ensured that an assessment was completed, the physician was notified, and the resident was provided emotional support along with the psychological services; and they would have reported the incident to the New York State Department of Health. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2024 at 12:47 PM, the Medical Director stated the Director of Nursing Services first made them aware of Resident #26's allegation of sexually inappropriate behavior by staff on 4/18/2024. The Medical Director stated they expect inappropriate behaviors toward the residents should not occur; however, when the resident made such an allegation, the accused staff should have been removed from the daily schedule and the allegation should have been investigated and reported promptly. The Medical Director stated regardless of the resident's accusatory behavior, any allegation of abuse of any kind should be fully investigated. The Medical Director stated that residents who have accusatory behaviors are at higher risk for abuse because they are not taken seriously and can often be taken advantage of because of this behavior. The Medical Director stated that Registered Nurse #1 should have reported the allegations of sexual abuse to the Director of Nursing Services, and it was not Registered Nurse #1's decision to decide not to investigate the allegation. 10 NYCRR 415.4(b)(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on observation, record review, and interviews during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility did not ensure a person-centered comprehensive care plan was reviewed and revised to address each resident's needs. This was identified for 1) one (Resident #114) of two residents reviewed for rehabilitation and restorative services; 2) one (Resident #227) of four residents reviewed for respiratory care; and 3) one (Resident #186) of five residents reviewed for unnecessary medications. Specifically, there was no documented evidence that the comprehensive care plans for Resident #114, Resident #227, and Resident #186 were reviewed and revised by the interdisciplinary team after each comprehensive and quarterly review assessment. The finding is: The facility's policy and procedure titled, Comprehensive Care Planning: Initial/Interim Care Plan effective 6/1/2002 and last reviewed in 4/2024, documented that an assessment will be completed on each newly admitted resident; the assessment information will be the basis of an Initial/Interim Care Plan, designed to guide caregivers until such time as the Comprehensive Care Planning Team can complete the formal care plan. The facility policy and procedure did not include that the comprehensive care plans are reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 1) Resident #114 was admitted with diagnoses that included Diabetes Mellitus with diabetic neuropathy, vitamin-dependent Rickets, and generalized Osteoarthritis. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15 indicating the resident was cognitively intact. The resident required partial/moderate assistance for eating and was dependent on staff for bed mobility and transfer. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13 indicating the resident had intact cognition; the resident required partial/moderate assistance for eating and was dependent for bed mobility and transfer. A comprehensive care plan titled Limited Physical Mobility related to difficulties with hands was created on 3/8/2023, with the last revision date of 9/19/2023. The comprehensive care plan documented the resident has been prescribed palm guards. The interventions included palm guards to be utilized as per the physician's order; providing a gentle range of motion as tolerated with daily care; and assistance with mobility as needed. There was no documented evidence that the comprehensive care plan was reviewed and or revised with the Minimum Data Set assessment schedule dated 11/3/2023 and 2/13/2024. Licensed Practical Nurse #3 was interviewed on 4/26/2024 at 12:35 PM and stated that the Licensed Practical Nurses are not allowed to initiate a care plan, but they are able to maintain/update and ensure that the plan of care is being followed. Licensed Practical Nurse #3 stated that the Registered Nurses are responsible to complete the quarterly care plan updates. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #4 was interviewed on 4/26/2024 at 12:54 PM and stated the care plans are reviewed and revised quarterly, annually, with significant change, and on an as-needed basis. The care plan review corresponds with the Minimum Data Set schedule. Registered Nurse #4 stated that the Minimum Data Set department is responsible for ensuring that all care plans are updated before the assessment is submitted to the Centers for Medicare and Medicaid Services. 2) Resident #227 was admitted with the diagnoses of Parkinson's Disease, Dementia, and Heart Failure. The 5-day Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10 which indicated the resident had moderately impaired cognition. The resident was dependent on staff for eating. The resident received oxygen and occupational and physical therapies. The quarterly Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status score of five which indicated the resident had severely impaired cognition. The resident required partial/moderate assistance with eating. The resident received speech-language and occupational therapies. The physician's orders dated 4/25/2024 Apixaban 5 milligrams every 12 hours for Atrial Fibrillation; Ceftriaxone (antibiotic medication) 1 gram intravenously every 24 hours for pulmonary infection for one week; and Ipratropium-Albuterol Solution 3 milliliter inhaler every six hours as needed for shortness of breath. A comprehensive care plan titled, Respiratory created 12/2/2023 with no revision date, documented the resident had altered respiratory status related to Chronic Obstructive Pulmonary Disease. The interventions included but were not limited to administering medication/puffers as ordered, monitoring for effectiveness and side effects, monitoring for signs and symptoms of respiratory distress, and reporting to the physician as needed. There was no documented evidence that the comprehensive care plan was reviewed and revised in accordance with the scheduled Minimum Data Set assessment dated [DATE]. Registered Nurse #2 was interviewed on 4/25/2024 at 12:25 PM and stated they are responsible for initiating and revising the residents' care plans. Registered Nurse #2 stated that the registered nurse on duty at the time of admission would initiate the care plans. Registered Nurse #2 stated that the comprehensive care plans are reviewed and revised at the care plan meetings, which correspond to the Minimum Data Set assessment schedule. Registered Nurse #2 stated they would also update the care plan if there were changes at the care plan meeting. 3) Resident #186 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, and Depression. A quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview of Mental Status was 14 which indicated the resident had intact cognition. Resident #186 required set-up assistance for eating and supervision for bed mobility and transfer. Resident #186 received antidepressant and anticoagulant medications. A quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview of Mental Status was 11 which indicated the resident had moderately impaired cognition. Resident #186 required set-up assistance for eating and supervision for bed mobility and transfer. Resident #186 received antidepressant, hypnotic, anticoagulant, and diuretic medications. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive care plan titled, Respiratory created on 6/14/2023 documented the resident was at risk for impaired gas exchange related to a history of Pneumonia and Chronic Obstructive Pulmonary Disease. The interventions included administering aerosol or bronchodilators as ordered, monitoring/documenting any side effects and effectiveness, monitoring for difficulty breathing (Dyspnea) on exertion, monitoring vital signs as per order, and supplemental oxygen as per physician orders. There was no documented evidence that the comprehensive care plan was reviewed and revised in accordance with the scheduled assessment of 11/3/2023 and 2/3/2024. A comprehensive care plan titled, Anticoagulant Therapy, created on 6/12/2023 documented the resident was on anticoagulant therapy, Eliquis related to Atrial Fibrillation. The interventions included administering anticoagulant medications as ordered by the physician, and monitoring for side effects and effectiveness every shift. There was no documented evidence that the comprehensive care plan was reviewed and revised in accordance with the scheduled assessment of 11/3/2023 and 2/3/2024. The Director of the Minimum Data Set was interviewed on 4/25/2024 at 12:41 PM and stated that the Minimum Data Set assessment is done by the Minimum Data Set coordinator and that nurses are responsible to initiate and review the care plans. The Director of the Minimum Data Set stated the registered nurse manager should be reviewing the care plan episodically (acute illness), if there is a change in status/medication, then the care plan should be updated. The Director of the Minimum Data Set stated that the care plans are reviewed and updated at each care plan meeting. An interview was conducted with the Director of Nursing Services on 4/25/2024 at 2:07 PM and stated that a Minimum Data Set assessment is completed on admission, quarterly, and annually. The Director of Nursing Services stated that at a minimum, the care plan should be reviewed with the Minimum Data Set schedule. 10 NYCCR 415.11(c)(2) (i-iii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024 the facility did not ensure each resident's environment was free from accident hazards and each resident received adequate supervision and assistance devices to prevent accidents. This was identified for one (Resident #226) of four residents reviewed for accident hazards. Specifically, Resident #226 was assessed as at risk for falls and had a history of falls. The resident's comprehensive care plan indicated a high floor mat as an intervention and a Dycem non-slip mat under the floor mat to prevent the high floor mat from slipping away from the resident's bed. During multiple observations, the Dycem non-slip mat was not observed under the high floor mats in Resident #226's room as indicated in the resident's comprehensive care plan. The finding is: The facility's policy titled, Resident Incidents and Accidents dated 2/2024 documented that the safety of the residents we serve is the facility's priority. The purpose of this policy is to maintain a proactive safety program congruent with the quality of life in which each resident is provided with a safe environment. Resident #226 was admitted with diagnoses that included Cerebral Infarction (a stroke), Hemiplegia (paralysis of one side of the body), and Hemiparesis (a weakness or the inability to move on one side of the body) affecting the Right Dominant Side, and Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score was not completed because the resident was rarely or never understood. A Comprehensive Care Plan for falls initiated on 5/8/2023 documented that Resident #226 was at risk for falls and injury due to a history of falls, impulsive behavior, and decreased range of motion. Interventions included but were not limited to floor mats to be placed on both sides of the bed and Dycem mats to be placed underneath both floor mats. A Nursing Progress Note dated 6/11/2023 documented Resident #226 was observed on the floor between the bedframe and high mat. A Nursing Progress Note dated 10/31/2023 documented Resident #226 was found lying on the floor by their bed. A Nursing Progress Note dated 11/15/2023 documented at approximately 4:00 AM Resident #226 was found sitting in between the bed and floor mat with their buttocks on the floor and their left leg under the floor mat. A Nursing Progress Note dated 11/21/2023 documented the resident was observed sitting upright with buttocks on the floor and their back against the bed with their extremities in front of them. The high mat was pushed away from the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for behavior initiated on 11/23/2023 documented Resident #226 had a behavior problem as evidenced by resident intentionally sliding and wiggling their way out of bed to the floor. An intervention was put in place for floor mats at the bedside with the addition of a Dycem mat to prevent sliding and wedging between the bed and the mat. A Nursing Progress Note dated 12/2/2023 documented Resident #226 was observed sitting next to the bed with their back against the bed and the high mats were pushed out to the side. On 4/17/2024 at 10:46 AM Resident #226 was observed in bed and to the right and left side of the resident's bed high floor mats were in place. On 4/24/2024 at 11:15 AM Resident #226 was observed in bed and high floor mats were placed to the right and left side of the bed. The floor mat on the left side of the bed was placed between the wall and the bed and did not move when pushed. There was no Dycem mat beneath the high floor mat. The high floor mat on the right side of the bed easily slipped out of place and there was no Dycem non-slip mat beneath the floor mat. On 4/24/2024 at 1:03 PM, an observation was made in the presence of Licensed Practical Nurse #11. Resident #226 was observed in bed with high floor mats in place and there were no Dycem mats beneath the high floor mats. Licensed Practical Nurse #11 was interviewed on 4/24/2024 immediately after the observation and stated they had observed Resident #226 suspended between the bed and the high floor mat. Licensed Practical Nurse #11 could not recall the day or time of this observation and stated they did not document the occurrence because the resident was not on the floor. Licensed. Licensed Practical Nurse #11 stated they were aware that Dycem mats had to be placed beneath the high floor mats to prevent the high floor mats from sliding away from the bed. Licensed Practical Nurse #11 looked in Resident #226's nightstand and located non-slip rug pads but Dycem mats were not located. Licensed Practical Nurse #11 placed the non-slip rug pads beneath the high floor mats. Certified Nursing Assistant #12 was interviewed on 4/24/2024 at 1:51 PM. Certified Nursing Assistant #12 stated they had never witnessed Resident #226 on the floor. Certified Nursing Assistant #12 stated the high floor mats were always in place and they have seen the non-slip rug pads beneath the high floor mats but have never seen Dycem mats in place. Certified Nursing Assistant #12 stated they do not recall the last time they saw the non-slip rug pads beneath the high mats. Certified Nursing Assistant #12 stated they did not document whether or not the Dycem mats were in place. Registered Nurse #7 was interviewed on 4/24/2024 at 2:04 PM and stated Resident #226 has a history of falls and the Dycem mats should be in place beneath the high mats to prevent the high mats from sliding away from the bed. The Director of Nursing Services was interviewed on 4/26/2024 at 4:43 PM and stated it was not acceptable to put the non-slip rug pads in place of the Dycem mats and that the Dycem mat should always be in place and checked by the Certified Nursing Assistants. The Certified Nursing Assistants were responsible for reporting missing Dycem mats to the charge nurse and the charge nurse would place a request in the maintenance log or if a safety concern call the maintenance department directly. 10 NYCRR 483.25(d)(1)(2)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024 the facility did not ensure that a resident who is fed by enteral means receives the appropriate treatment, care, and services to prevent complications of enteral feeding. This was identified for two (Resident #148 & Resident #69) of three residents reviewed for Tube Feeding. Specifically, 1) on 4/17/2024 at 10:49 AM and again on 4/25/2024 at 12:05 PM Resident # 148's tube feeding bottles were not labeled including nursing's initials, date, and time the feeding was initiated. 2) Certified Nursing Assistant #7 was observed providing care to Resident #69 while the resident was lying flat on their back in the bed. The resident was receiving the tube feeding while the lying flat. The findings are: 1) The facility policy titled, Enteral Feeding Via Gastrostomy Tube last reviewed February 2024 documented to replace disposable formula bottles, tubing sets, and syringes every 24 hours and label each item with date and time. Resident #148 was admitted with diagnoses of Cerebral Infarction, Dysphagia (difficulty swallowing), and Aphasia (speech impairment). The Annual Minimum Data Set assessment dated [DATE] documented that Resident #148 rarely or never understood and a Brief Interview for Mental Status score was not conducted. Resident #148 has a feeding tube and receives more than 51 percent of their total calories and 501 cubic centimeters or more fluid through tube feeding per day. The physician's orders dated 3/6/2024 documented to administer Glucerna 1.2 (tube feeding formula) at 75 milliliters per hour via the feeding tube with a water flush of 75 milliliters every hour during feeding. The amount of fluid to be administered in 24 hours (formula and the water flush) is 3000 milliliters. The Tube Feeding Comprehensive Care Plan last revised on 3/7/2024 documented that Resident #148 has the potential for alteration in tube feeding. Resident #148 required tube feeding as the primary source of nourishment and hydration and received pureed, honey/moderately thick consistency pleasure food three times a day. Interventions included monitoring for gastric complications, caloric intake, and estimated needs, and to make recommendations for changes to tube feeding as needed. During an observation on 4/17/2024 at 10:49 AM Resident #148 was observed in a Geri-lounge chair next to their bed. The tube feeding and hydration bottles were observed hanging on a feeding pole and the tube feeding was being administered to the resident via a feeding pump. The feeding and hydration bottles did not have a label, including the nurse's initials, date, and time the feeding was initiated. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/25/2024 at 12:05 PM, Resident #148 was observed in bed. The tube feeding and hydration bottles were observed hanging on a feeding pole and the tube feeding was being administered to the resident via a feeding pump. The feeding and hydration bottles were dated 4/24/2024 and were labeled with the resident's room number. The label did not include the nurse's initials and the time the feeding was initiated. The tube feeding label was observed again on 4/25/2024 with Licensed Practical Nurse #6 at 12:08 PM who stated that the bottle should have a start time and the flow rate so that it can be compared against the flow rate on the monitor to ensure the feeding is running at the accurate rate. Licensed Practical Nurse #6 was interviewed on 4/26/2024 at 11:11 AM and stated that they worked on the 3:00 PM - 11:00 PM shift on 4/16/2024 and initiated tube feeding for Resident #148 at 5:00 PM as per the physician's order. Licensed Practical Nurse #6 stated they hung a 1500 milliliter bottle of tube feed and labeled the bottle with the resident's information as indicated. Licensed Practical Nurse #7 who administered the resident's feeding tube on 4/24/2024 in the evening shift (3:00 PM- 11:00 PM) was contacted on 4/25/2024 and 4/26/2024 and was unavailable for an interview. Registered Nurse Supervisor #5 was interviewed on 4/26/2024 at 11:23 AM and stated the nurse who administered the tube feeding should label the bottle with the date and time the tube feeding bottle was hung. The Director of Nursing Services was interviewed on 4/26/2024 at 4:29 PM and stated the nursing staff should have labeled the tube feeding bottle. The nursing staff should verify the feeding bottle with the physician's orders, and date, and indicate the time when the feeding bottle was hung to be able to monitor if the resident is receiving the total feed according to the prescribed order. 44925 2) The policy and procedure for Enteral tube feedings dated 2/2024 documented the resident's head of the bed should be elevated at 30 to 45 degrees unless contraindicated while [the tube feeding] formula is running. Resident #69 was admitted with diagnoses including Cerebral Infarction and Gastrostomy (feeding tube). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident was rarely/never understood. The Minimum Data Set also documented the resident utilized a feeding tube. The Comprehensive Care Plan (CCP) for Feeding Tubes dated 9/15/2023 last reviewed on 4/12/2024 documented interventions that include the head of the bed to be elevated at 45 degrees during feedings and thirty minutes after the tube feed; monitor, document, and report any signs of aspiration, fever, tube dislodgement, infection at the tube site and tube dysfunction or malfunction. The Physician's orders dated 4/8/2024 documented to administer Jevity 1.5 (calorically dense, fiber-fortified therapeutic nutritional tube feeding formula) 1000 milliliters at 50 milliliters/hour and automatic flush with 50 milliliters per hour during feeds. Elevate HOB at 30-45 degrees position every shift for aspiration precaution. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/2024 at 9:52 AM, Resident #69 was observed in bed. Certified Nurse Assistant #7 was providing morning care to the resident and Certified Nursing Assistant #8 was assisting. The resident was lying flat on their back in a supine position (lying horizontally with the face and torso facing up) and the tube feeding formula was observed running at 50 cubic centimeters/hour. Certified Nursing Assistant #7 was interviewed on 4/23/2024 immediately after the observation and stated they were aware that the resident's tube feeding was running. Certified Nursing Assistant # 7 stated they had notified Licensed Practical Nurse (LPN) #8 to turn off the tube feeding formula prior to providing care to the resident. Certified Nurse Assistant #8 was interviewed on 4/25/2024 at 8:00 AM and stated they did not realize the resident's tube feeding was attached. They were not assigned to Resident #69 and were only there to assist Certified Nurse Assistant #7. Certified Nurse Assistant #8 stated they were aware that the resident should not be lying flat when the tube feeding is running because of the risk of aspiration. Licensed Practical Nurse # 8 was interviewed on 4/25/2024 at 8:02 AM and stated the resident should not be lying flat in bed during the tube feeding; the feeding has to be stopped and disconnected by the nurse prior to providing care to the resident to prevent aspiration. Licensed The Licensed Practical Nurse stated they were not called to disconnect the tube feeding before Certified Nursing Assistant #7 started to provide morning care to Resident #69. The Director of Nursing Services (DNS) was interviewed on 4/25/2024 at 8:28 AM and stated the resident cannot be in a flat in bed while the tube feed is running as this may cause the resident to aspirate. The Certified Nursing Assistant #7 should have notified a nurse to pause the tube feed before providing care to the resident. Medical Doctor #2 was interviewed on 4/25/2024 at 8:53 AM and stated the tube feeding formula should have been paused if the head of the bed was below 45 degrees to avoid aspiration. 10 NYCRR 415.12(g)(1-7)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observations, interviews, and record reviews conducted during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility did not ensure that residents who require dialysis receive such services, consistent with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident #152) of two residents reviewed for dialysis. Specifically, the dialysis center recommended holding Resident #152's blood pressure medications before the dialysis treatments. The facility staff did not follow the recommendations made by the dialysis center and did not notify the resident's Physician of the recommendations. The finding is: The Policy and Procedure for Hemodialysis: Transporting the Resident, last revised in January 2022 documented the Licensed Nurse sends a communication book to the dialysis center with the resident and includes requests for blood tests and any other pertinent information in the communication book. The Licensed Nurse reviews the communication book for pertinent information that needs a follow-up, notifies the Physician, and obtains orders as needed. The Licensed Nurse writes/picks up telephone orders as per Facility protocol. Resident #152, was admitted with diagnoses that include End Stage Renal Disease (ESRD) and Hypertension. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident's Brief Interview for Mental Status (BIMS) score was not completed because the resident was rarely/never understood. The Minimum Data Set assessment also documented that the resident received dialysis treatment. The Physician orders dated 2/8/2024 include dialysis treatment every Tuesday/Thursday/Saturday at an offsite Kidney Center. The physician orders dated 3/16/2024 documented to administer Lasix (diuretic) Tablet 20 milligrams- give 1 tablet via feeding tube one time a day for Congestive Heart Failure (CHF) and to administer Metoprolol Tartrate Tablet 25 milligrams - Give 2 tablets via feeding tube every 8 hours for Hypertension. The Dialysis Comprehensive Care Plan (CCP) last revised on 4/19/2024 documented the resident receives dialysis treatment due to right Renal Cancer, status post right Nephrectomy, and a diagnosis of End Stage Renal Failure. Interventions include to monitor the left atrioventricular Fistula (a procedure that connects an artery to a vein in preparation for dialysis) for Bruit (whooshing sound)/Thrill (vibrations caused by blood flowing through the fistula) every shift and to monitor for signs and symptoms of bleeding infection to the left atrioventricular Fistula every shift. A review of the resident's Dialysis Communication book revealed that on 4/16/2024 the dialysis center staff gave instructions to the facility to hold the resident's blood pressure medications before dialysis treatments. These instructions were not addressed by the facility staff. A review of the resident's medical record revealed that the instructions to hold the blood pressure medications from the dialysis center were not communicated to the resident's physician. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Administration Record revealed that Lasix and Metoprolol medications were not held for Resident #152 on 4/18/2024 and 4/20/2024 prior to the resident's dialysis treatments. Licensed Practical Nurse # 1, who was assigned to the resident on 4/16/2024, was not available for interview. The Director of Nursing Services was interviewed on 4/23/2024 at 11:30 AM and stated that Licensed Practical Nurse #1 should have acknowledged the dialysis center's communication upon the resident's return from the dialysis center on 4/16/2024 and should have contacted the resident's Physician for directions. The Director of Nursing Services stated that the blood pressure medications were administered to Resident #152 on 4/18/2024 and 4/20/2024 and the recommendations made by the dialysis center were not followed. Physician Assistant # 1 for Resident #152 was interviewed on 4/25/2024 at 2:55 PM and stated if the dialysis center made changes to the resident's treatment regimen or provided any recommendations, the Physician, Physician Assistant, or the Nurse Practitioner should have been made aware. Physician Assistant #1 stated they were not aware of the recommendations made by the dialysis center on 4/16/2024. Physician Assistant #1 further stated that they may not have necessarily held the blood pressure medications because of the resident's Atrial Fibrillation diagnosis; however, would have ordered to monitor the blood pressure and provided the parameters regarding when to hold the resident's blood pressure medications. 10 NYCRR 415.12

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28173 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024, the facility did not ensure that drug records were in order and accounted for all controlled drugs. This was identified in three (Unit 1C, Unit 3C, and Unit 3B) of seven nursing units reviewed for Medication Storage. Specifically, 1) the daily control drug count sheet on Unit 1C was not signed by two Licensed Nurses to reflect a physical count of the available controlled medications. Additionally, the daily control drug count sheet was not reconciled to reflect the available controlled medications in the medication blister pack for Resident #130 (Unit 1C). 2) the daily control drug count sheet on Unit 3C was not signed by two licensed nurses to reflect a physical count of the available controlled medications. Additionally, the Controlled Drug Record form on Unit 3C was not reconciled to reflect the available controlled medications in the medication blister pack for Resident #170 (Unit 3C). 3) the daily control drug count sheet on Unit 3B was not signed by two licensed nurses to reflect a physical count of the available controlled medications. The findings are: 1) Resident #130 was admitted with diagnoses including Cerebral Palsy, Chronic Pain Syndrome, and Aphasia. The 4/9/2024 Quarterly Minimum Data Set assessment documented Resident #130 had a short/long term memory problem and severely impaired cognition for daily decision making. A physician's order effective 4/11/2024 documented to administer Oxycodone (a controlled substance used to treat pain) 5-milligram tablet, one tablet via Gastrointestinal Tube every 12 hours for generalized pain for seven days. During an observation of Unit 1C's medication room, with Licensed Practical Nurse #5, on 4/25/2024 at 2:50 PM, the daily control drug count sheet was reviewed for the period of 4/21/2024 to 4/27/2024. Licensed Nurses' signatures were noted to be missing at the beginning of the shift for the 7:00 PM-7:00 AM count on 4/21/2024, the 7:00 AM-7:00 PM count on 4/22/2024, the 7:00 PM-7:00 AM count on 4/22/2024, and the 7:00 AM-7:00 PM count on 4/25/2024. A manual count of Resident #130's controlled medications was performed by Licensed Practical Nurse #5 in the presence of one of the registered nurse surveyors. Resident #130's daily control drug count sheet for Oxycodone documented 29 tablets of Oxycodone were remaining; however, the blister pack for Oxycodone had 30 tablets. Licensed Practical Nurse #5 was interviewed on 4/25/2024 immediately after the observation. Licensed Practical Nurse #5 stated they may have taken the Oxycodone tablet from Resident #130's other blister pack and recorded the count inaccurately in the record. Licensed Practical Nurse #5 stated that they forgot to sign the drug control sheet at the beginning of their shift on 4/25/2024. Licensed Practical Nurse #5 stated that the error was an oversight and that the drug control sheet should have been signed in the presence of another nurse to reflect an accurate count of the controlled substance at hand. An observation was conducted immediately after the interview with Licensed Practical Nurse #5 on 4/25/2024 related to the remaining Oxycodone blister packs for Resident #130. The count was found to be accurate as documented for the other blister packs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medical Director was interviewed on 4/26/2024 at 1:10 PM and stated that reconciliation of controlled substances by licensed nurses is necessary at the change of every shift to keep track of controlled substances. The Director of Nursing Services was interviewed on 4/26/2024 at 1:15 PM and stated that a manual count and signing of the daily control drug count sheet must be done by two licensed nurses at the commencement of every shift because reconciliation of the daily control drug count sheet is necessary to keep track of controlled substances. 44963 2) Resident #170 was admitted with diagnoses including Dementia with Anxiety, Major Depressive Disorder, and Altered Mental Status. The Admission Minimum Data Set assessment dated [DATE] documented that Resident #170 had a Brief Interview for Mental Status score of 8 which indicated moderately impaired cognition. Resident #170 did not receive any Anti-Anxiety medication at admission. A physician's order dated 4/11/2024 documented to administer Xanax (a controlled substance used to reduce Anxiety) 0.25-milligram tablet, one tablet by mouth every 12 hours as needed for anxiety. During an observation of Unit 3C's medication room on 4/26/2024 at 10:24 AM, the low side unit's daily control drug count sheet was reviewed for the period of 4/21/2024 to 4/27/2024. Licensed nurses' signatures were noted to be missing at the beginning of the shift for the 11:00 PM-7:00 AM count on 4/24/2024, the 3:00 PM-11:00 PM count on 4/25/2024, and the 7:00 AM-3:00 PM count on 4/26/24. Licensed Practical Nurse #9, who was the assigned nurse to work on the low side of Unit 3C on 4/26/2024, was interviewed at on 4/26/2024 10:26 AM. Licensed Practical Nurse #9 stated they had counted and reconciled the narcotic count sheet with the outgoing nurse at the beginning of their shift today (4/26/2024). Licensed Practical Nurse #9 stated they forgot to initial the daily control drug count sheet after completing the count and it was an oversight. Licensed Practical Nurse #9 stated the daily control drug count sheet should be initialed by both nurses after the count is completed. During the observation, the unit's high-side daily control drug count sheet was reviewed on 4/26/2024 at 10:31 AM. A manual count of Resident #170's controlled medications was conducted with Licensed Practical Nurse #6. Resident #170's blister pack of Xanax 0.25 milligram had 32 remaining tablets and the Controlled Drug Record form for Resident #170's Xanax documented 32 tablets remaining; however, the daily control drug count sheet that was reconciled by Licensed Practical Nurse #6 indicated 31 tablets were remaining. Licensed Practical Nurse #6 was interviewed on 4/26/2024 immediately after the observation and stated that they counted and reconciled all residents' controlled drugs with the outgoing nurse at the beginning of their shift (7:00 AM-3:00 PM) today, 4/26/2024. Licensed Practical Nurse #6 stated they saw the number of tablets remaining on the Controlled Drug Record form matched the actual count in the blister pack and that is why they initialed the daily control drug count sheet. Licensed Practical Nurse #6 stated they did not notice the daily control drug count sheet documented an inaccurate count of Resident #170's Xanax. Licensed Practical Nurse #6 stated that the daily control drug count sheet should document 32 tablets of Xanax instead of 31 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services was interviewed on 4/26/2024 at 4:26 PM and stated that both outgoing nurses and incoming nurses at the beginning of each shift must conduct a count of all narcotic medications together. The Director of Nursing Services stated that nurses must ensure the blister pack, the Controlled Drug Record form, and the daily control drug count sheet should reflect the accurate count of each narcotic available on the unit. The Director of Nursing Services further stated that each nurse must initial the daily control drug count sheet together. 41051 3) During an observation of Unit 3B's medication room on 4/26/2024 at 10:26 AM, the low side unit's daily control drug count sheet was reviewed for the period of 4/21/2024 to 4/27/2024. Licensed nurse signatures were noted to be missing at the beginning of the shift for the 3:00 PM-11:00 PM count on 4/21/2024, the 11:00 PM- 7:00 AM count on 4/21/2024, and the 7:00 AM-3:00 PM count on 4/26/2024. Licensed Practical Nurse #10, who was the assigned nurse to work on the low side of Unit 3B on 4/26/2024, was interviewed on 4/26/2024 at 10:29 AM. Licensed Practical Nurse #10 stated they had counted and reconciled the daily control drug count sheet with the outgoing nurse at the beginning of their shift on 4/26/2024. Licensed Practical Nurse #10 stated they did not sign the unit's daily control drug count sheet that morning because they normally sign the book at the end of their shift. Licensed Practical Nurse #10 stated they were never trained or in-serviced on how the count was supposed to be done and when they should sign for it. The Inservice Coordinator/Staff Educator was interviewed on 4/26/2024 at 10:43 AM. The Inservice Coordinator/Staff Educator stated that during training, the licensed nurses should have been trained to sign off on the unit's daily control drug count sheet at the beginning of their shift when they conducted the count. The Inservice Coordinator/Staff Educator stated when a Licensed Practical Nurse is new to the facility they initially work with a mentor nurse on the unit who trains the new nurse and the training includes the procedure for the narcotic drug count. The Director of Nursing Services was interviewed on 4/26/2024 at 4:21 PM and stated that both the outgoing nurse and the incoming nurse must conduct a count of all narcotic medications together. The Director of Nursing Services stated once the count is completed both licensed nurses should sign the unit's daily control drug count sheet. 10 NYCRR 415.18(b)(1)(2)(3)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, interviews and record review conducted during the Recertification Survey initiated on 4/17/24 and completed on 4/26/24, the facility did not ensure that residents are free of any significant medication errors. This was identified for two (Resident #79 and Resident #143) of seven residents reviewed for choices. Specifically, 1) Resident #79 did not receive their physician-ordered Insulin injection timely 2) Resident #143 had a physician's order to check blood sugar via a fingerstick before meals. The blood sugar via a fingerstick was not performed in the ordered time frame, and Insulin was not administered according to the Physician's order before meals. The finding is: 1) Resident #79 was admitted with diagnoses that included Type II Diabetes Mellitus and Hypertension. A Quarterly Minimum Data Set assessment dated [DATE] documented Resident #79 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The Minimum Data Set assessment documented that Resident #79 received an Insulin injection daily during the assessment period. The facility policy and procedure for Use of Insulin Sliding Scale Orders and Blood Sugar Fingerstick Testing, revised on 4/2024, documented the nurse shall administer sliding scale Insulin in accordance with the written prescriber's order and shall advise the practitioner of any critical value immediately. Resident #79's Physician's order dated 8/1/2023 and last updated on 4/20/2024 documented to administer Basaglar Kwik-Pen (a long-acting basal insulin used to control high blood sugar) Subcutaneous Solution Pen-injector 100 Unit per milliliter, Inject 10 unit subcutaneously one time a day for Diabetes Mellitus. Hold for blood sugar level below 70 milligrams per deciliter. A Comprehensive Care Plan dated 6/19/2023 documented Resident #79 had altered endocrine functioning related to Diabetes Mellitus. The interventions included to monitor, document, and to report signs and symptoms of hyperglycemia. Resident #79's Medication Administration Record dated 4/18/2024 documented to inject Basaglar Insulin Kwik-Pen 10 units subcutaneously at 9:00 AM. The Medication Administration Record revealed the actual administration time of the Insulin was at 10:58 AM, an hour and 58 minutes after the scheduled administration time which was 9:00 AM. 2) Resident #143 was admitted with diagnoses that included Diabetes Mellitus and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented Resident #143's Brief Interview for Mental Status score was 15, which indicated intact cognition. The Minimum Data Set assessment documented Resident #143 received Insulin injections daily during the assessment period. Resident #143's Physician's order dated 1/15/2024 and last updated on 4/22/2024 documented Novolog (Insulin) Injection Solution 100 Units per milliliter, Inject as per sliding scale subcutaneously before meals for Diabetes. The resident's insulin coverage based on the blood glucose levels was as follows: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-70 milligrams per deciliter to 100 milligrams per deciliter inject 0 units of insulin; -101 milligrams per deciliter to 150 milligrams per deciliter inject 100 units of insulin; -151 milligrams per deciliter to 200 milligrams per deciliter inject 12 units of insulin -201 milligrams per deciliter - 250 milligrams per deciliter inject 14 units of insulin -251 milligrams per deciliter - 300 milligrams per deciliter inject 16 units of insulin -301 milligrams per deciliter - 350 milligrams per deciliter inject 18 units of insulin -351 milligrams per deciliter - 400 milligrams per deciliter inject 20 units of insulin -401 milligrams per deciliter - 999 milligrams per deciliter inject 22 units of insulin -Call the Physician if the blood sugar is below 60 milligrams per deciliter or above 400 milligrams per deciliter. Resident #143's Comprehensive Care Plan dated 3/1/2023 and last updated on 6/14/2023 documented that Resident #143 had altered endocrine status related Diabetes Mellitus. Interventions included to administer Diabetes medication as ordered by the doctor, to monitor, and to document side effects and effectiveness. Resident #143's Medication Administration Record dated 4/2024 documented Resident #143's blood sugar level was 204 milligrams per deciliter and 14 units of insulin were administered. A Review of the Administration Record Audit Report dated 4/18/2024 documented that 14 units of Novolog Injection Solution were administered to Resident #143 after their breakfast meal at 10:18 AM. Licensed Practical Nurse #12 was interviewed on 4/18/2024 at 1:15 PM and stated that they were late with medication administration because they were very busy. Registered Nurse #1 was interviewed on 4/19/2024 at 1:05 PM and stated both Resident #79 and Resident #143 received their insulin late because they were expecting the second nurse by 8:00 AM who did not arrive until approximately 9:00 AM. Registered Nurse #1 stated when there is one medication nurse on the unit the nurse is responsible for administering medication for the whole unit including obtaining blood sugar levels via finger sticks and they (Registered Nurse #1) were responsible for completing the treatments for the high side of the unit. Registered Nurse #1 stated that they did not instruct Licensed Practical Nurse #13 to do the finger stick for Resident #79 and #143; however, when there is one medication nurse the process is for that nurse (Licensed Practical Nurse #13) to complete all the fingersticks on the unit. Registered Nurse #1 stated that they (Registered Nurse #1) should have completed the fingerstick until the second medication nurse (Licensed Practical Nurse #12) arrived on the unit. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #13 was interviewed on 4/26/2024 at 1:30 PM and stated they were the assigned medication nurse on the high side of the unit on 4/18/2024. Licensed Practical Nurse #13 stated there were supposed to be two nurses scheduled for the medication administration on the unit; however, the second medication nurse (Licensed Practical Nurse #12), who was assigned to the low side, did not arrive on the unit until 8:50 AM. Licensed Practical Nurse #13 stated they started the medication administration on their assigned high side at 9:00 AM but did not complete the blood sugar checks for the residents on the low side because the second medication nurse was expected to arrive earlier than 8:50 AM. Licensed Practical Nurse #13 stated the second medication nurse arrived on the unit at 8:50 AM while they (Licensed Practical Nurse #13) were in the process of reviewing the Medication Administration Record to check if any blood sugar checks and early medication administration were needed for residents on the low side of the unit. Licensed Practical Nurse #13 stated that they asked Registered Nurse #1 for assistance with taking the residents' vitals on the low side but did not ask for assistance in completing the fingersticks Physician #3 was interviewed on 4/26/2024 at 3:43 PM and stated that it was important that the blood sugar of a diabetic resident should be strictly monitored and insulin should be administered according to the Physician's order. The Physician stated when blood sugar is not monitored as ordered and Insulin is not administered as ordered by the Physician, serious complications such as Ketoacidosis (a serious complication of diabetes) can occur. The Physician stated that the nurse should ensure the resident's blood sugar is monitored and insulin is administered according to the Physician's order. The Director of Nursing Services was interviewed on 4/26/2024 at 4:08 PM and stated that they expect the staff to follow the physician's order including obtaining the fingerstick blood glucose levels and administering insulin according to the Physician's orders. The Director of Nursing Services stated that the Physician should be made aware when insulin was not administered as ordered and an assessment should be completed by the Registered Nurse to ensure there are no signs or symptoms of Hyperglycemia. The Director of Nursing Services stated they expected Registered Nurse #1 to assist with ensuring the residents' fingersticks were completed and insulin was administered. 10 NYCRR 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/17/2024 and completed on 4/26/2024 the facility did not ensure each resident in a semi-private room had ceiling suspended curtains, which extend around the bed to provide total visual privacy. This was identified for two (Resident #108 and Resident #111) of two residents reviewed for privacy. Specifically, Resident #108 and Resident #111 shared a semi-private room. The privacy curtain separating Resident #108 and Resident #111 was not long enough to allow full visual privacy. The finding is: The facility's policy titled, Privacy Curtains effective 4/2024 documented the purpose of this policy is to establish guidelines for the use and maintenance of privacy curtains in our nursing facility to ensure the privacy and dignity of our residents. The curtains should cover the entire length of the resident's bed area and provide full privacy. Resident #108 was admitted with diagnoses that included Cerebral Vascular Accident (stroke), Congestive Heart Failure, and Hypertension (high blood pressure). The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 12 indicating the resident had moderately impaired cognition. Resident #108 was interviewed on 4/17/2024 at 11:32 AM and stated their roommate (Resident #111) played with [themselves] and it is gross and it made them (Resident #108) uncomfortable. Resident #108 stated that they told staff members; however, could not recall the names or when they reported to the staff. On 4/26/2024 at 5:42 PM Resident #108 was observed in bed and the privacy curtain was pulled between Resident #108's and Resident #111's beds. A gap was observed between the bottom of the privacy curtain and the floor. Resident #111 was in bed, and they could be visualized from Resident #108's bed through the gap. A second interview was conducted with Resident #108 on 4/26/2024 at 5:42 PM. Resident #108 stated they could see Resident #111 while they were lying in their bed because the privacy curtain was too short. Resident #108 stated Resident #111 regularly placed their hand under their clothing and moved their hand back and forth and it made them (Resident #108) feel uncomfortable and it is gross. Resident #108's Comprehensive Care Plan was reviewed and there was no documented evidence that a concern with Resident #111 was identified or addressed. Resident #111 was admitted with diagnoses that included Respiratory Failure, Aphasia (the inability to speak well), and Encephalopathy (a disease that affects the brain). The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 9 indicating the resident had moderately impaired cognition. Resident #111's Comprehensive Care Plan was reviewed and there was no documented evidence that Resident #111's behavior of touching their genitals was identified or addressed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #10 was interviewed on 4/26/2024 at 9:51 AM and stated that Resident #111 did play with themselves and was not aware that the behavior made Resident #108 uncomfortable. Certified Nursing Assistant #11 was interviewed on 4/26/2024 at 9:55 AM and stated Resident #111 did play with themselves, and Resident #108 reported to Certified Nursing Assistant #11 that Resident #111's behavior made them uncomfortable. Certified Nursing Assistant #11 stated they reported Resident #108's concern to the charge nurse. Licensed Practical Nurse #10 was interviewed on 4/26/2024 at 10:04 AM and stated Resident #111 played with himself; however Licensed Practical Nurse #10 did not know that Resident #108 was uncomfortable with Resident #111's behavior. Social Worker #2 was interviewed on 4/26/2024 at 2:28 PM and stated they were not aware that Resident #108 was uncomfortable sharing a room with Resident #111. Social Worker #2 stated a Care Plan Meeting took place with Resident #108 on 4/11/2024 and Resident #108 did not state a concern with Resident #111. Social Worker #2 stated if they had been made aware Resident #108 had a concern with Resident #111 they would have interviewed both residents, documented any concerns, updated the comprehensive care plan, and developed interventions. Registered Nurse #3, the unit manager, was interviewed on 4/26/2024 at 3:41 PM and stated they were not aware that Resident #108 was uncomfortable with Resident #111 behavior. Registered Nurse #3 stated if the issue had been reported to them, they would inform the Social Worker and update the resident's comprehensive care plan. A second interview was conducted with Certified Nursing Assistant #10 on 4/26/2024 at 5:48 PM. Certified Nursing Assistant #10 stated the privacy curtain between Resident #108 and Resident #111's beds has always been short and they (Certified Nursing Assistant #10) did not realize Resident #108 could see Resident #111 from their (Resident #108's) bed. Registered Nurse #6 was interviewed on 4/26/2024 at 5:56 PM. Registered Nurse #6 stated she was the Registered Nurse Supervisor on the unit. Registered Nurse #6 observed the curtain length and stated the curtain was too short because Resident #108 was able to see Resident #111 through the gap in the bottom of the curtain. Registered Nurse #6 stated the curtain should be replaced because it does not give the residents privacy. The Director of Environmental Services was interviewed on 4/26/24 at 6:07 PM. The Director of Environmental Services stated they were not aware that the curtain in Resident #108's room was too short and did not provide privacy to the residents who resided in that room. The Director of Environmental Services stated the maintenance staff are responsible for hanging up the privacy curtains and they should make sure that the curtain provided privacy. The Director of Nursing Services was interviewed on 4/26/2024 at 6:19 PM. The Director of Nursing Services stated the privacy curtain should ensure full privacy to each resident in their room when sharing a room and the facility staff should know that each resident has a right to privacy. The Director of Nursing Services stated that during care the staff person should ensure the resident's privacy. 10 NYCRR 415.29