STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335845	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Ctr for Rehabilitation and Brain Injury	300 Grant Avenue Lake Katrine, NY 12449

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation and interview conducted during the recertification survey from 11/13/24 to 11/21/24, the facility did not ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior were provided. Specifically, 1) room [ROOM NUMBER] A/B had soiled walls with chipped paint/scratches/holes, garbage can was soiled/privacy curtains were stained and 2) feeding tube pumps and/or poles contained dried formula for five residents (#35, #193, #172, #215, #150) on the VENT unit. The findings are: 1) On 11/13/24 at 11:31 AM room [ROOM NUMBER] B was observed to have walls in disrepair with holes, scratches, and chipped paint. The room had an odor of urine. On 11/13/24 at 11:32 AM room [ROOM NUMBER] A was observed to have walls soiled with stains, and areas of disrepair such as chipped paint, holes, and scratches. The privacy curtain was soiled and stained. The wall near the garbage and dresser had brown soiled stains on it. The dresser and garbage were also soiled with brown stains. The room had an odor of urine. On 11/13/24 at 12:44 PM during a family interview for Resident #17, they stated their only concern is housekeeping and the floors could be kept clean. On 11/14/24 at 10:13 AM room [ROOM NUMBER] A was observed to have walls soiled with stains, and areas of disrepair such as chipped paint, holes, and scratches. The privacy curtain was soiled and stained. The wall near the garbage/dresser and the dresser had brown stains. The room had an odor of urine. On 11/14/24 at 10:14 AM room [ROOM NUMBER] B was observed to have walls in disrepair with holes, scratches, and chipped paint. The room had an odor of urine. During and interview/observation of room [ROOM NUMBER] A/B on 11/21/24 at 12:15 PM the Director of Housekeeping went to room [ROOM NUMBER] A and 324 B with this surveyor to observe the room. The Director of Housekeeping stated there was an odor of urine. The Director of Housekeeping stated the rooms are supposed to be cleaned daily. They stated they did not know why the room had not been cleaned. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 1:30PM the Maintenance Assistant stated they were not aware of the chipped paint and the damaged walls in room [ROOM NUMBER] A and 324 B. The Maintenance Assistant stated they do have a system for staff to log maintenance issues into the computer for review but there was no documented evidence that indicated these issues had been logged. The Maintenance Assistant stated if they were made aware of the issues in room [ROOM NUMBER] A and 324 B, they would have addressed and repaired them immediately. 2) During an observation on 11/13/24 at 10:35 AM the tube feeding pump/pole for Resident #35 had dried formula. During an observation on 11/13/24 at 10:40 AM the tube feeding pump for Resident # 193 had dried formula. During an observation on 11/13/24 at 10:48 AM the tube feeding pump for Resident # 172 had dried formula. During an observation on 11/13/24 at 10:54 AM the tube feeding pump for Resident #215 had dried formula. During an observation on 11/13/24 at 11:01 AM the tube feeding pump for Resident # 150 had dried formula. During an interview on 11/21/24 at 10:47 AM the Regional Director of Housekeeping stated housekeeping may wipe the tube feeding pumps/poles when cleaning the rooms. During an interview on 11/21/24 at 10:50 AM the Director of Housekeeping stated that the feeding tube pumps located in resident rooms are supposed to be cleaned when the room is cleaned daily. 10 NYCRR 415.5(h)(2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on interview and record review conducted during the recertification and abbreviated surveys (#NY00340049 and #NY00351730) from 11/13/24-11/21/24, the facility did not make prompt efforts to resolve grievances or inform the complainant of the grievance investigation outcome for 2 (Resident #177 and #72) of 2 residents reviewed for grievances. Specifically, 1) for Resident #177, there was no evidence that grievances were documented on the tracking log in the grievance book, or that the complainant was notified of the outcome of the grievance and 2) Resident #72's friend stated they made a verbal complaint to the social worker and no grievance was initiated. The findings are: Policy & Procedure titled Grievance/Complaint Procedure that was last revised on 8/2024 documented; when grievances are made it is procedure to keep a detailed tracking log of such concerns. Within ten (10) working days of the date the report was filed, the complainant will be informed of the results of the investigation. 1)Resident #177 had diagnoses including Anoxic Brain Injury and Hypoxic Ischemic (an injury to the brain caused by a lack of oxygen to the brain) Encephalopathy (a term for any brain disease). The 7/5/24 Quarterly Minimum Data Set (an assessment tool) documented Resident # 177 had severe cognitive impairment. The 6 grievances for Resident #177 documented 1) Facetime Calls dated January 2024, 2) No Nail Care dated ongoing, 3) No oral care dated ongoing, 4) Discharge Planning dated ongoing, 5) Not providing splints dated August, and 6) Hand Splints dated Ongoing. The grievances were not logged in the grievance book and had no documentation that the grievance or corrective action was reviewed with the individual making the grievance. During an interview on 11/19/24 at 8:58 AM Resident #177's family member stated they had spoken with the social worker regarding their concerns. They stated they were unaware how to complete a grievance and were unaware if a grievance had been created. They stated no one from the facility notified them that a grievance had been filed/outcome of the investigation. During an on 11/19/24 at 10:15 AM the Administrator stated the facility has postings throughout the building regarding grievances. They stated the Grievance Officer was responsible for documenting grievances on the form/log, following up with department heads, and completing an investigation with outcome. They stated the Grievance Officer should than notify the person making the grievance of the outcome. They stated the Grievance Officer who created these grievances is currently out on sick leave and they do not know why the grievances were not recorded in the log and why there was no documentation of complainant notification. 2) Resident #72 admitted to the facility on [DATE] with the following diagnoses, Non-Traumatic Brain Dysfunction, Seizure Disorder and Psychotic Disorder. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/11/24 Quarterly Minimum Data Set (MDS) documented Resident #72 was cognitively intact. On 11/21/24 at 10:09 AM complainant stated on 8/30/24 they tried to get confirmation of being able to take a friend out to a store/restaurant. They stated they made the request on Monday, and Wednesday but did not receive an answer back. They stated a timely reply by the facility should go both ways. Complainant stated they filed a verbal complaint with the Social Worker, but because of phone tag, little is done. They stated a month ago, they asked for a complaint form, which they have not received. There was no documented evidence in the January 2024 Grievance Log of grievance/s related to Resident #72. On 11/20/24 at 10:35 AM Social Worker #3 stated they have no grievance for Resident #72. Social Worker #3 stated Resident #72' friend did try to file a complaint and was directed to the Liaison for assistance. The Social Worker stated they take information from the complainant, document it, and refer the information to the Liaison or the Director of Social Work. They stated the Liaison is supposed to document the complaint on a complaint form. Social Worker #3 stated they believe Resident #72's friend had started a complaint about taking the resident out on pass. On 11/21/24 at 9:57 AM Grievance Officer and Liaison were unavailable for interviews. 10 NYCRR 415.3(d)(1)(i) 45478

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44673 Based on observation, record review and interview conducted during the Recertification and Abbreviated Surveys (NY 00350609) from 11/13/24-11/21/24, the facility did not ensure resident's rights to be free from abuse for 2 of 8 residents (Residents #102 and #73) reviewed for abuse. Specifically, interventions were not implemented as per care plan and/or physician order for Resident #102 with a history of physical aggression and documented episodes of verbal aggression on 8/6/24 at 3:00PM, 4:00 PM and 5:00 PM, resulting in Resident #102 punching Resident #73 on the right side of their head on 8/6/24 at 7:00 PM. Findings include: The 11/13/03 policy with a revision date of 6/24 titled Increased Supervision and Close Visual Observation documented additional supervision for those individuals who are at risk, may be at risk of injury, or who may place others at risk. Close Visual Observation (one staff member monitoring resident always.) The Community Support Specialist must report any issues of concern to the nurse on duty. The policy with a revision date of 9/24 titled Abuse documented residents were protected from abuse, neglect, mistreatment, or misappropriation of property. Physical abuse was defined as including hitting, slapping pinching, and kicking. Resident #102 was admitted with diagnoses including but not limited to Depression, Traumatic Brain Dysfunction and Muscle Weakness. The 2/9/24 Comprehensive Care Plan titled Behaviors documented close visual observation for safety. Observe for signs of intent to harm self or others. Monitor behavior and update physician as needed. The 2/10/24 Physician Order documented close visual observation (one:one) every day, every shift. The 2/10/24 Physician Order documented retain on the behavior unit for safety of self and others. The 2/24 Comprehensive Care Plan titled Potential to Abuse Others documented history of altercations and abusing others. Observe for signs of agitation in overly stimulated areas, redirect, remove other residents from the area, cease interactions and return after agitation has diffused. The 7/12/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #102 had moderately impaired cognition, generally understood others/ made self understood, exhibited no behaviors and was independent in activities of daily living. The 8/6/24 Close Visual Observation Form documented Resident #102 had three verbally aggressive episodes (talk that threatens physical harm.) at 3:00 PM, 4:00 PM, and 5:00 PM. There was no documented evidence the behavior was reported to the Nurse. The 8/6/24 (7:00 PM) Incident Report documented Resident# 102 walked up and punched Resident #73 on the right side of the head but the peer did not retaliate. Behavior code was called. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/12/24 Investigative Summary documented Resident #102 had care plans in place and goals that focus on decreasing impulsive behaviors by helping him to remain focus on favorable task. Staff have also been trained that when behavior/s escalate to allow a structured cooling off period to promote de-escalation as well as offering active listening to promote stabilization. There was no reason to suspect abuse, neglect, mistreatment, or misappropriation of property. During observation on 11/13/24 at 10:05 AM Resident #102 was sitting on their bed with a Community Support Specialist Staff #7 sitting at their doorway. At that time Community Support Specialist #7 stated the resident requires one to one supervision for behaviors, suicidal ideation's, throwing chairs, and hitting other residents. During an interview on 11/19/24 at 10:35 AM, Community Support Specialist #8 stated they were aware of the physical altercation between Residents #102 and #73. They stated when assigned to Resident #102 they are mindful of the reason residents are placed on close visual observation. They stated while working with the residents they prioritize maintaining arm's length supervision when necessary, and report any issues to the nurse. They stated they receive training in recognizing and managing abuse and is experienced in working with residents with traumatic brain injury. During an interview on 11/19/24 at 11:35 AM, Social Worker #1 stated they met with Resident #102 following the incident to assess for psychological trauma. They stated Resident #102 recalled the incident but expressed a desire to move forward.They stated Resident #73 had a history of sexually inappropriate behavior toward staff members. They further stated Resident #102 believed they were protecting the staff. During an interview on 11/19/24 at 10:53 AM, the Director of Nursing stated they initiated the investigation and collected staff statements. They stated on the day of the altercation the Community Support Specialist # 7 did not follow Resident #102 down the hallway, and Resident #102 attacked Resident #73. They further stated the nurse on the unit was responsible for supervising Community Support Specialists. During a follow up interview on 11/19/24 at 11:23 AM the Administrator stated they were aware of the physical altercation between Resident #102 and Resident #73. They stated the staff member involved was terminated due to a care plan violation. The care plan required observing for signs of agitation in overly stimulated areas, redirecting and removing other residents from the area. Additionally, Resident #102 had verbal aggression behaviors which had not been reported to the nurse. 10 NYCRR 415.4(b)(1)(i)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43478 Based on record review and interview conducted during the recertification and abbreviated surveys (NY00348027, NY00343016, NY00340876, NY00346752, and NY00344233) from 11/13/24 to 11/21/24, the facility did not ensure that the residents and/or resident representatives were notified in writing of the reason for the transfer/discharge to the hospital in a language that they understood for 2 of 8 (#676 and #677) residents reviewed for hospitalization , and the facility did not notify the Ombudsman for 8 of 8 residents (Residents #233, #676, #677, #234, #573, #164, #199, #211) reviewed for hospitalization . The findings are: The facility policy and procedure, Transfer and Discharge Rights, reviewed 6/2024, documented that all residents who are emergently sent to the hospital shall require a Notice of Transfer/Discharge which will be provided to the resident and the resident's representative in writing and in a language and manner that they will understand, and the facility will notify the Long term Care Ombudsman. 1.Resident #233 was admitted with diagnoses including stroke, brain and spinal cord dysfunction, and nondramatic intracerebral hemorrhage. The 4/10/24 Quarterly Minimum Data Set (resident assessment) documented Resident #233 had intact cognition and impairments to one side to upper and lower extremities. The 5/6/24 Nurse's Note documented seizure activity, blood pressure 160/94, heart rate 112, and temperature 99.3. The Nursing Supervisor and Respiratory Therapist responded, the Nurse Practitioner was called. The resident given a one time dose of Hydralazine for elevated blood pressure and sent to emergency room for evaluation. There was no documented evidence the Ombudsman was notified of Resident #233's transfer to the hospital. 40686 2) Resident #676 was admitted to the facility with diagnoses of amyotrophic lateral sclerosis (a neurodegenerative disease) and respiratory failure. The 5/21/24 Admission Minimum Data Set 3.0 documented Resident #676 was cognitively intact. The 6/25/24 Nursing Note documented Resident #676 had a change in condition and was transferred to the hospital. There was no documented evidence Resident #676 was provided a notice of transfer in writing in a language they understand explaining the reasons for their transfer to the hospital on 6/25/2024. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence the Ombudsman was notified of Resident #676's transfer to the hospital. 3) Resident #677 was admitted to the facility with diagnoses of bipolar disorder and chronic obstructive pulmonary disease. The 4/16/24 Admission Minimum Data Set 3.0 (resident assessment) documented Resident #677 was moderately cognitively impaired and had a Health Care Proxy. The 5/25/24 Nursing Note documented Resident #677 was transferred to the hospital due to deep breathing and an 89% pulse oximeter value while breathing on room air. There was no documented evidence Resident #677 and their Health Care Proxy were provided a notice of transfer in writing in a language they understand explaining the reasons for their transfer to the hospital on 5/25/2024. There was no documented evidence the Ombudsman was notified of Resident #677's transfer to the hospital. During an interview on 11/19/2024 at 10:18 AM Social Worker #1 stated they did not have any information regarding notification of discharges sent to the Ombudsman. During an interview on 11/19/2024 at 11:42 AM Assistant Administrator stated they could not find documentation that the Ombudsman was notified of any resident discharges to the hospital. They stated the Director of Social Work was solely responsible for notifying the Ombudsman, and the Director of Social Work was currently out sick. During an interview on 11/21/2024 at 9:44 AM the Ombudsman stated they did not receive any transfer/discharge notices from the facility for discharges to the hospital from January 2024 through the present date. 10 NYCRR 415.3(i)(1)(iii)(a-c) 45478 47626 49364

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, record review conducted during the recertification and abbreviated (NY00348027 and NY00340876) from 11/13/2024 to 11/21/2024, the facility did not ensure baseline care plans were developed and implemented for each resident. This was evident for 3 (Resident #676, #677, and #208) of 41 total sampled residents. Specifically, 1) a baseline care plan was not developed for Resident #676 upon their admission to the facility on [DATE], 2) a baseline care plan was not developed for Resident #677 upon their admission to the facility on [DATE], and 3) a baseline care plan was not developed within 48 hours of Resident #208's admission to the facility. The findings are: The facility policy titled Baseline Care Plan dated 2/2024 documented the baseline care plan must be developed within 48 hours of admission or readmission. 1) Resident #676 was admitted to the facility on [DATE] with diagnoses of amyotrophic lateral sclerosis (a neurodegenerative disease) and respiratory failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #676 was cognitively intact. There was no documented evidence a Baseline Care Plan was developed and implemented for Resident #676 within 48 hours of their admission to the facility on [DATE]. 2) Resident #677 was admitted to the facility on [DATE] with diagnoses of bipolar disorder and chronic obstructive pulmonary disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #677 was moderately cognitively impaired and had a Health Care Proxy. There was no documented evidence a Baseline Care Plan was developed and implemented for Resident #677 within 48 hours of their admission to the facility on [DATE]. 47626 3) Resident #208 was admitted to the facility on [DATE] with diagnoses of cerebral infarction and acute respiratory failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #208 had severe cognitive impairment. There was no documented evidence of a completed Baseline Care Plan prior to 10/31/2024. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 1:33 PM Registered Nurse Unit Manager stated Resident #208 was admitted to the facility on [DATE] and the Baseline Care Plan was completed on 10/31/2024. The Registered Nurse Unit Manager stated they were responsible for completing the resident's Baseline Care Plan and was not working when Resident #208 was admitted to the facility. They stated they completed the Baseline Care Plan upon their return to work. During an interview on 11/21/2024 at 02:49 PM, Assistant Director of Nursing #2 stated the Baseline Care Plan form does not automatically populate when the admitting nurse triggers a resident's admission orders/forms in the electronic medical record. They stated the admitting nurse was responsible for triggering the Baseline Care Plan using the hospital discharge paperwork and any other available medical records. Assistant Director of Nursing #2 stated they and the Director of Nursing were responsible for overseeing and ensuring the completion of Baseline Care Plans. During an interview on 11/20/24 at 11:08 AM the Director of Nursing stated the unit nurse managers were responsible for completing Baseline Care Plans. They stated Nursing Supervisors should complete the Baseline Care Plans for residents admitted to the facility on Friday evenings and/or the weekend. They stated the nurse management team was responsible for completing Baseline Care Plans if the unit nurse manager was on leave/ vacation. The Director of Nursing stated they were not aware of issues related to Baseline Care Plans. 10 NYCRR 415.11

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43478 Based on observation, record review, and interview conducted during the recertification and abbreviated (NY00349188, and NY00349049) surveys from 11/13/24 to 11/21/24, the facility did not ensure each resident who was unable to carry out activities of daily living received the necessary care and services to maintain good personal hygiene for 2 (Residents #212 and #177) of 9 residents reviewed for Activities of a Daily Living. Specifically, Resident #212 and #177 who required dependent assistance with Activities of Daily Living, did not receive showers as scheduled for multiple months according to the Certified Nurse Aide documentation. The findings are: The facility policy, Activities of Daily Living, reviewed 3/1/2022, documented showers or baths are scheduled and assistance is provided when required. Resident #212 was admitted with diagnoses including unspecified injury of cervical spinal cord, need for assistance with personal care, and generalized muscle weakness. The 6/14/24 Quarterly Minimum Data Set assessment documented Resident #212 had intact cognition and required dependent assistance with showers. The 8/30/24 Comprehensive Minimum Data Set assessment documented, tub shower transfer not assessed/no information. The ADL/Mobility Care Plan documented Bathing: dependent with shower/bath -helper performs all, 2-person tub/shower transfers. Two-person type shower evening, Wednesday, Friday. Interventions: Resident prefers showers. Report to nurse if resident refuses personal hygiene or bathing. The current Shower List documented Resident #212 was scheduled for showers on Wednesdays and Fridays, on the evening shift. The July 2024 Bathing Record documented Resident #212 received a shower on 7/5/24. The August 2024 Bathing Record documented Resident #212 received a shower on 8/13/24, 8/18/24, and 8/23/24. The September 2024 Bathing Record documented Resident #212 received a shower on 9/4/24, 9/6/24, 9/18/24, 9/20/24, and 9/27/24. The October 2024 Bathing Record documented Resident #212 received a shower on 10/02/24 and 10/4/24. The November 1-November 2024 documented Resident #212 received a shower on 11/13/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 1:15 PM, Resident #212 stated they had not been getting scheduled showers. They stated the aide did not offer showers on scheduled shower days (Wednesday and Friday evenings). Resident #212 stated at the end of the shift on shower days, the aide would tell the resident they forgot the resident was scheduled for a shower. Resident #212 stated they spoke with the Unit Manager about this issue a few times, but it did not improve. During an interview on 11/14/24 at 3:53 PM, Certified Nurse Aide #2 stated they regularly provided care to Resident #212 on the evening shift. They stated they did not give a shower to Resident #212 last Friday November 8th because they forgot, and stated they also forgot to report the missed shower to the nurse. They stated they knew where the shower list was posted, and the Certified Nurse Aide assignment sheets documented the scheduled showers for each shift. During an interview on 11/14/24 at 4:04 PM with Registered Nurse Unit Manager #1, a review was conducted of Resident #212's Shower Records for October and November 2024, which documented the Resident only received 2 showers in October and 1 shower in November. Registered Nurse Unit Manager #1 stated the nurses should make the Certified Nurse Aide assignments and document the assigned showers on the assignment sheet, and should assure scheduled showers are completed on the shift. Registered Nurse Unit Manager #1 stated Resident #212 complained to them in March or April about scheduled showers not being provided. Registered Nurse Unit Manager #1 stated they tried to address the problem by re-arranging the shower list to help the staff complete assigned showers. Registered Nurse Unit Manager #1 stated they held a meeting in October with Certified Nurse Aide #2 and Resident #212 during which Resident #212 clarified they wanted showers but was not getting them. During a follow-up interview on 11/18/24 at 10:40 AM with Registered Nurse Unit Manager #1, a review was conducted of Resident #212's Shower Records for July, August, and September which documented the Resident only received 1 shower in July, 3 showers in August and 5 showers in September. Registered Nurse Unit Manager #1 stated Resident #212 should have received 8 showers per month. They stated they had not been aware of the number of showers the resident had missed in July, August, September, October, and November. On 11/18/24 at 11:13 AM during an interview, Registered Nurse Supervisor #4 stated they frequently work the overnight shift from 7 PM to 7 AM. They stated the Certified Nurse Aides should complete the showers assigned to them. During an interview on 11/19/24 at 12:16 PM, the Director of Nursing stated if a resident reported lack of showers back in April, the issue should have been addressed within a few days, not longer than that. The Director of Nursing stated the aides should provide showers as assigned. The Director of Nursing stated that if a resident reports they are not getting showers, the Unit Manager should check the Resident's Bathing Record and the Certified Nurse Aide assignments to see who was responsible for the resident's showers, interview the aide to find out the reason showers were not completed, and interview the resident to find out what problems might be causing showers to not be completed. 47626 2)Resident #177 had diagnoses including hypoxic ischemic (an injury to the brain caused by a lack of oxygen to the brain), encephalopathy (a term for any brain disease). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Ctr for Rehabilitation and Brain Injury	300 Grant Avenue Lake Katrine, NY 12449

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/5/24 Quarterly Minimum Data Set documented the resident's cognition was severely impaired and the resident was dependent on staff with all other activities of daily living. The May 1, 2024- July 30, 2024 Nurse Aide Record documented showers were completed on 5/5/24, 5/9/24, 5/10/24, 5/12/24, not at this time on 5/6/24, 5/13/24, and 5/30/24 and shower provided on 6/24/24. There was no documented showers from 6/24/24-7/21/24. The Care Plan titled Activities of Daily Living with a revision date of 10/28/24 documented showers on Tuesday and Friday in the evenings and report to the nurse if the resident refuses a shower. During an interview on 11/20/24 at 2:00 PM Registered Nurse Unit Manager #1 stated Resident #177 was scheduled for showers 2 times a week and they were not aware showers were not documented by the Certified Nurse Aide. They stated they found it hard to believe the resident was not showered from 6/17/24-7/22/24 and felt it was more likely that staff did not have time to document due to the low staffing on the unit. During an interview on 11/21/24 at 9:45 AM Certified Nurse Aide #10 stated if the resident is due to have a shower staff should document if the shower was received or if the shower was refused refused. During an interview on 11/21/24 at 12:00 PM the Director of Nursing stated they were aware the shower documentation has been an issue, and they have been working on it. They stated they were not aware of the issue with lack of shower documentation and/or shower provided for Resident #177. They stated the nurse managers run a report at the end of the shift to view missed documentation. During an interview on 11/21/24 at 12:10 PM the Assistant Administrator stated they looked for documentation related to Resident #177's showers from 6/17/24-7/22/24 and could not locate any additional documentation. They stated they did not know why this was not noted at the time of the completed Grievance or why it had not been addressed at the time. 10 NYCRR 415.12(a)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49364 Based on observation ,record review and interview conducted during the recertification and abbreviated (NY00344233 and NY00340876) surveys from 11/13/2024 through 11/21/2024, the facility did not ensure 3 of 3 residents (#573, #677 and # 87) reviewed for quality of care received treatment and care in accordance with the professional standards of practice. Specifically, 1) a follow-up Urology appointment was not provided for a newly placed suprapubic catheter for Resident #573, 2) Resident #677 did not receive a Neurology consultation as recommended in their hospital discharge instructions and 3) Resident #87 with limited range of motion of bilateral lower extremities was observed in a high back chair, sliding down with their buttocks resting at the end of the seat, both knees were bent/both feet were positioned behind the knees. The findings are: The facility policy titled Admission/Readmission of the Resident Neighbor dated 5/2024 documented licensed staff verified orders with the Physician, transcribed orders, and filled out other diagnostic test slips. 1) Resident # 573 was admitted with diagnoses including neuromuscular dysfunction of bladder, seizure disorder, and anoxic brain damage. The 9/10/2024 Quarterly Minimum Data Set (an assessment tool) documented Resident #573 was dependent on staff for their activities of daily living and no coding was documented for Resident #573's cognition. The 10/01/2024 Physician Progress Note documented the resident returned to the facility from the hospital on 9/26/24 after being sent in on 9/17/2024 with temperatures 101.8 to 103.2, F and elevated heart rate and found to be in septic shock from Urosepsis. Physician progress note documented an increase in creatinine and blood urea nitrogen was likely an indication of obstructive uropathy from the indwelling foley catheter, and the resident had several bladder stones extracted. During the resident's hospitalization on [DATE], they had surgery for placement of suprapubic catheter on 9/24/2024. The Urologist advised that first change of the suprapubic catheter at 30 days will have to be completed at the urologist's office. The 11/5/2024 Nursing Progress Note at 12:30 AM documented Resident's Blood Pressure, Lying: Left Arm: Systolic 133 / Diastolic: 80: Pulse: 150: Respiration: 35 Temperature(F): 98.7: Pulse Oximetry: 100. Resident had no urine output in the urine bag, Irrigated the resident's suprapubic catheter and it was blocked. Changed new catheter French 16 aseptically and was irrigated, noted back flow in the tubing and some coming out from penile meatus. After an hour noticed an increase in heart rate from the central monitor, checked the resident who was in distress, vital signs taken and recorded, the resident's heart rate was 145-150+H Respiratory Rate of 30-35 and with facial grimacing. Resident had no urine output in the urinary drainage bag. Flushed the suprapubic catheter and observed back flow in the tubing and some in the urinal meatus. Deflated the balloon and observed large frank blood coming from penile meatus. Applied ice compress and called Nursing supervisor. Tylenol dose was given. At 0200 AM, the resident's physician was made aware, ordered to put new suprapubic catheter, and send to emergency room for evaluation. 911 and the hospital emergency room was called. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 10:11 AM, Resident # 573's family members stated the resident had surgery for suprapubic catheter on 9/24/2024. Stated the Urologist from the hospital recommended the suprapubic catheter. The resident's family stated the facility did not follow up in 30 days. They stated the Registered Nurse Unit Manager on the Vent Unit was to make the appointment because of transportation issues. Family member stated during a care plan meeting 10/10/2024 the facility stated they are having problems with transportation, and the facility's plan was to bring the resident to the emergency room to have the suprapubic catheter change, but never gave a time when this would happen. During an interview on 11/19/2024 at 5:57 PM, Registered Nurse Supervisor # 6 stated they changed the resident's supra pubic catheter. They stated the suprapubic catheter was clogged, the resident had hematuria and was sent out to the hospital. During an interview on 11/20/2024 at 9:24 AM, Unit Clerk/ Clerk Supervisor stated the resident had an appointment on October 28, 2024, at 1 PM, but the resident did not make it to the appointment. They stated the reason was the ambulance company stated they were no longer doing medical doctor's appointments for residents on ventilators, the resident was on a Ventilator. They stated the resident's physician and urologist were in the process of setting up an appointment to send the resident to the hospital to have the supra pubic catheter change, but it never happened. During an interview on 11/21/2024 at 09:05 AM, Registered Nurse Unit Manager # 5 stated registered nurses can change suprapubic catheters. They stated they believe the resident's suprapubic catheter should not have been changed by the nurse before the resident had their first urology appointment. During an interview on 11/21/2024 at 4:32 PM, the Urology Nurse at the Urologist office stated the resident was to have a follow-up for their first suprapubic catheter change this October and did not offer any further information. During an interview on 11/21/24 at 5:13 PM, Physician #1 stated the resident needed to see the urologist for the first catheter change which was delayed by lack of ambulance services. They stated on the night of 11/5/24 at about 12:30 AM the catheter became blocked, the nurse tried to clear it and could not clear it and realized it was an issue and emergently changed it because the resident's heart rate was very fast. They stated after the nurse changed the suprapubic catheter they noticed the resident was discharging secretions and had backflow of urine, then blood coming from the resident penile meatus, so they were contacted, and the nurse deflated the balloon. They stated they told the nurse to leave the suprapubic tube in and send the resident to the emergency room . They stated it was all emergent, the resident pulse was 150. They stated because it was emergent that is why it was done otherwise it would not have been done here absolutely, but there would have been no reason to change it unless it got blocked the resident became symptomatic. 40686 2) Resident #677 was admitted with diagnoses of bipolar disorder, dysphagia, and cognitive communication deficit. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #677 was moderately cognitively impaired and did not document their neurological diagnoses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hospital Discharge Instructions dated 4/10/2024 documented Resident #677 needed to schedule a Neurology follow up appointment within 1 to 2 weeks of their discharge. The Nursing Note dated 4/10/2024 documented Resident #677 was admitted to the facility from the hospital following a syncopal episode at home, the Nurse Practitioner would assess, and the orders were placed. The Nurse Practitioner Note dated 4/10/2024 documented Resident #677 was evaluated by Neurology on 4/5/2024 for evaluation of dementia. Neurology ordered labs and noted Resident #677's tremors were thought to be related to Depakote side effects. The assessment and plan included a Neuropsychology consult. The Nursing Note dated 5/25/2024 documented Resident #677 was transferred to the hospital. There was no documented evidence a Neurology consultation was ordered or completed for Resident #677 in accordance with Hospital Discharge Instructions dated 4/10/2024. On 11/21/2024 at 02:49 PM, Assistant Director of Nursing #2 was interviewed and stated the admitting nurse was responsible for reviewing Hospital Discharge Instructions and transcribing orders for the facility's new admissions. On 11/21/2024 at 01:52 PM, Nurse Practitioner #1 was interviewed and stated they were called by the admitting nurses to reconcile medications and admission orders for newly admitted residents. Nurse Practitioner #1 stated they personally review the entire discharge summary including the Hospital Discharge Instructions to ensure the admission orders were accurate and complete. Nurse Practitioner #1 stated they were responsible for ordering consults recommended in the Hospital Discharge Instructions and the nurse was responsible for ensuring the consult gets scheduled. There were times that consultation with specialists outside the facility were postponed because of issues with transportation or a resident's insurance. Nurse Practitioner #1 stated they ordered a Neuropsychology consult for Resident #677 upon their admission to the facility. A Neurology consult was not ordered for Resident #677. Nurse Practitioner #1 stated a Neuropsychologist was not the same as a Neurologist, and they did not know the reason the Neurology consult was not ordered. Nurse Practitioner #1 stated the facility did not have a Neurologist that came in to the facility to assess residents. On 11/21/2024 at 01:11 PM, Physician #1 was interviewed and stated follow up consultations with outside physicians were ordered and arranged for newly admitted residents as recommended by the hospital discharge paperwork. Physician #1 stated that they interface with Neurologists in the hospital as needed. The facility had recent difficulties with arranging for transportation for residents to go to outside consults due to changes in ownership of the available transportation service. The transportation company informed the facility they would only provide emergency transportation and would no longer provide transportation for scheduled appointments. 45478 3) Resident #87 was admitted to the facility with diagnoses including Progressive Neurological Condition, Diabetes Mellitus, and Contracture. The 9/24/24 Physician Order documented Physical Therapy evaluation and treat as necessary. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/11/24 Rehabilitation Screen documented no change with eating, oral/personal hygiene, toilet hygiene/toileting, upper dressing, lower dressing, putting on/taking off footwear, roll left/right, chair/bed to chair transfer. The 11/1/24 Quarterly Minimum Data Set (resident assessment) documented the resident had moderate impairment in cognition, no behaviors, limited range of motion in the bilateral lower extremities and was dependent of staff for toileting, bed mobility and transfer. During interview on n 11/19/24 at 11:32 AM Resident #87 was observed in a high back chair, sliding down with their buttocks resting at the end of the seat. Both knees were bent and the feet were positioned behind the knees. During interview on 11/20/24 at 4:49 PM, the Director of Rehabilitation stated they felt there was change in the resident's condition and they will need a Broda chair. The Director of Rehabilitation stated the last time they worked with the resident on wheelchair positioning was in May of 2024. The 11/20/24 Physical Therapy evaluation documented the resident was referred to Physical Therapy due to increased difficulty with out of bed positioning. Resident presents with severe flexor withdrawal synergy. Bilateral lower extremity synergy was exacerbated with tactile stimulation and an attempt to stretch. Resident did not respond to slow, gently, prolonged stretch. Resident with left lateral deviation of bilateral lower extremities in supine or in wheelchair sitting . Although resident's existing, personal wheelchair was previously adjusted to meet the resident's positional needs, their condition appears to have changed and necessitates a new intervention. The 11/21/24 at 1:26 PM, Certified Nurse Aide #22 stated the resident was put in the wheelchair in good position prior to going to eat lunch that day but stated the resident slides down. Certified Nurse Aide #22 stated in the past 4 months, they have been working with the resident and the resident has been consistently sliding down in their wheelchair. Certified Nurse Aide #22 stated they did alert nursing staff, but do not know what happened. Certified Nurse Aide #22 stated the facility used a lot of agency nurses and felt maybe they never followed up after they communicated the issues regarding the residents positioning. Certified Nurse Aide #22 stated they have a lack of communication with rehabilitation and the certified nurse aides do not have an option of leaving a note in their documenting system. The 11/21/24 at 1:29 PM, Licensed Practical Nurse #24 stated when they observed the resident in the dining room during lunch they did not think the resident was positioned correctly. Licensed Practical Nurse #24 stated the foot rest also looked lopsided Licensed Practical Nurse #24 stated they repositioned the resident in the chair that day but felt the leg rest was still not right. 10 NYCRR 415.12

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the recertification and abbreviated (NY00348027) survey from 11/13/2024 to 11/21/2024, the facility did not ensure a resident received care to prevent pressure ulcers. This was evident for 1 (Resident #676) of 7 residents reviewed for Pressure Ulcers. Specifically, Resident #676 was admitted to the facility with redness to their buttocks and did not receive a comprehensive skin assessment until they developed a stage 3 facility-acquired sacral pressure sore. The findings are: The facility policy titled Skin/Pressure Injury Preventions and Intervention Program dated 4/2024 documented a risk assessment for pressure injury will be completed by the Registered Nurse upon admission and every week for 4 weeks after admission. Weekly skin evaluations will be done on every resident. 1) Resident #676 had diagnoses of amyotrophic lateral sclerosis (a neurodegenerative disease) and respiratory failure. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #676 was cognitively intact, totally dependent upon caregivers to provide bed mobility, and clinically assessed to be at risk for developing pressure ulcers. Resident #676 did not have any unhealed pressure ulcers at the time of the assessment. The Nursing Note dated 5/17/2024 documented Resident #676 was admitted to the facility and had 2 small round red areas to the buttock. A Skin assessment dated [DATE] documented Resident #676 was bedfast, had very limited mobility, had skin rarely exposed to moisture, had a potential problem with friction and shearing, and had adequate nutritional intake. The Skin Assessment documented Resident #676 was at mild risk for pressure sores. Resident #676 was scheduled to have their next Skin Assessment within 1 week. A Physician Order dated 5/18/2024 documented Resident #676 have their skin checked daily during the day and evening shifts. There was no documented evidence the Physician ordered a treatment regime to address the 2 red areas on Resident #676's buttocks identified by the nurse on 5/17/2024. The Comprehensive Care Plan related to risk for skin impairment initiated 5/20/2024 documented Resident #676 was bedfast and risk for friction shearing and interventions to prevent skin breakdown included weekly skin assessments, skin observation during care, and turning/positioning every 2 hours. A Wound assessment dated [DATE] documented on 6/5/2024, a stage 3 facility-acquired pressure ulcer was identified on Resident #676's sacrum. The Nursing Note dated 6/13/2024 documented Resident #676 was evaluated by the wound care team and coccyx continues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to impaired skin integrity was initiated 6/18/2024 and documented Resident #676 was observed by the wound care team on 6/13/2024 for a stage 3 sacral pressure ulcer. The Medical Doctor Note dated 6/17/2024 documented Resident #676 had a stage 3 sacral pressure ulcer. A Nursing Skin Check Form documented Resident #676 had no areas of concern on their skin daily from 5/18/2024 to 6/18/2024. There was no documented evidence Resident #676 received ongoing and accurate Skin Assessments to monitor and prevent Resident #676's risk for and development of a stage 3 sacral pressure ulcer. On 11/21/2024 at 02:33 PM, Assistant Director of Nursing #2 was interviewed and stated they were also the facility's Wound Care Nurse and was responsible for assessing residents with identified skin conditions and coordinating with the Wound Care Doctor for wound rounds and treatments. Assistant Director of Nursing #2 stated nurses on the units performed skin checks of residents at risk for developing pressure ulcers weekly during bathing. Residents were not required to have a pressure ulcer regularly assessed. Nurses were responsible for documenting skin checks on the Medication Administration Record and informed the Wound Care Nurse via email or by telephone if a resident was found to have a wound. The facility began using a new skin assessment software program in 4/2024 that did not interface with their electronic medical record. The Wound Assessments and other wound round documentation were not accessible by the nurses on the units using the facility's electronic medical record. Assistant Director of Nursing #2 stated they had to document twice in both electronic software applications to ensure communication and continuity of care. After reviewing Resident #676's medical record, Assistant Director of Nursing #2 acknowledged that they performed the Wound Assessment of Resident #676 on 6/6/2024. Assistant Director of Nursing #2 confirmed that there was a Nursing Note documenting Resident #676 had 2 small red areas to their buttocks on 5/17/2024 and no other documentation referring to Resident #676's coccyx, sacrum, or buttocks until Assistant Director of Nursing #2 wrote their note on 6/6/2024. Assistant Director of Nursing #2 stated it was theirs and the Director of Nursing's responsibility to oversee the completion and accuracy of assessments performed by the nurses on the units. Assistant Director of Nursing #2 was unable to provide and explanation for the gap in assessment and documentation regarding Resident #676's 2 red areas upon admission to when their stage 3 pressure ulcer was identified. On 11/21/2024 at 01:11 PM, Physician #1 was interviewed and stated they were unable to provide a timeline for Resident #676's stage 3 sacral/coccyx ulcer development and identification. Resident #676 came from the hospital without any pressure sores because the facility was unable to match the staffing in the hospital. The Certified Nursing Assistants did their best to turn the resident every 2 to 4 hours but were not always staffed to do so. Weekly wound rounds only included residents with skin conditions. Nurses on the units were able to refer any resident to be placed on wound rounds at any time by communicating with the Physician and/or Assistant Director of Nursing #2. 10 NYCRR 415.12(c)(1-2)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45478 Based on record review and interview conducted during the recertification and abbreviated surveys (NY00346752) from 11/13/2024 to 11/21/2024, the facility failed to ensure the plan of care for each resident was followed and that adequate supervision and/or assistance was provided to prevent accidents for 1 of 8 residents (Resident #234) reviewed for Abuse. Specifically, Resident #234 required a 2- person assist for transfers and the Certified Nurse Aide #25 attempted to transfer the resident without assistance of another staff member. Subsequently, Resident #234 fell and sustained a laceration (a cut or tear in the skin) to the back of their head which required eight staples. This resulted in actual harm that is not immediate jeopardy for Resident #234. The findings are: Resident #234 was admitted to the facility with the diagnosis of Traumatic Brain Injury, Aphasia (disorder affecting a persons ability to understand/express language) and Mood Disorder. The 4/24/2024 Quarterly Minimum Data Set (resident assessment), documented Resident #234 had severe cognitive deficits, was dependent on staff for all Activities of Daily Living, required 2-staff assist for transfers and had 1 fall since the last assessment. The 6/27/2024 Accident & Incident Report documented Certified Nurse Aide #25 was interviewed and described the incident where they showered the resident on the shower trolley (a mobile solution for showering in a lying position) and then attempted to transfer the resident to the bed by themselves.While doing this the resident rolled to the floor between the bed and trolley. Certified Nurse Aide #25 called for help, the nurse responded to the room, and assessed the resident. The Registered Nurse Supervisor also responded and assessed the resident. The physician was notified, and orders were received to send the resident to the hospital. Certified Nurse Aide #25 acknowledged they were aware of the current plan of care and did not follow it. Certified Nurse Aide #25 acknowledged they did not ask others for assistance. The 6/27/2024 Employee Statement from Certified Nurse Aide #25 documented they gave the patient a shower and after the shower was finished and completed, they covered the resident and wheeled them to their room. They put the trolley up to the bed for resident transfer. The resident rolled over the trolley railings, slid down between the trolley and their bed and hit the floor. The resident's head hit the floor. They lifted the resident's head to put a cushion under their head, that's when they noticed the resident was bleeding from the back of their head where they hit the floor. A code was called and 911 was called. The ambulance arrived and the resident was taken to the hospital. The 6/27/2024 Hospital Records documented the resident had a fall after a shower, no fracture/s identified. The resident required sutures to the back of their head. The entire laceration was closed with staples. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 6/27/2024 At Risk for Fall Care Plan evaluation note documented after a shower, Certified Nurse Aide #25 brought the resident back to the room via the shower trolley for transfer back to bed. Certified Nurse Aide #25 stated the resident rolled themselves off the trolley onto the floor, striking their head. The resident was transferred to the emergency room for further assessment. Certified Nurse Aide #25 was re-educated on transfer safety and procedure. The 6/28/2024 At Risk for Fall Care Plan evaluation note documented the resident returned at approximately 10:30 PM on 6/27/2024 with staples to their posterior (back) head. The 10/21/2024 with no creation date tracking history Care Plan titled Activities of Daily Living documented Resident #234 had impaired performance and physical mobility and was dependent in all activities of daily living and required assist of 2 persons for transfer. The 10/21/2024 with no creation date tracking history Care Plan titled At Risk for Falls documented risk for falls related to pain, recent illnesses with decline in activities of daily living, confusion with impaired judgement. Interventions included wear proper foot-wear/nonskid socks, Physical Therapy or Occupational Therapy evaluation, maintain bed in lowest position, call bell within reach, bilateral floor mats when in bed, complete fall risk assessment. During an interview on 11/19/2024 at 10:10 AM the Administrator stated they did suspend and terminate Certified Nurse Aide #25 for failing to follow the residents plan of care. The Administrator stated Certified Nurse Aide #25 reported other staff were busy, so they decided to attempt the transfer alone. The Administrator stated the care plans were originally initiated prior to 10/21/2024 and that the care plans were in place prior to 10/21/2024 but there was no way to show the tracking of the history other than the notes written in the evaluation notes section of the care plan. During an interview on 11/20/2024 at 2:21 PM the Physician stated the fall did not cause permanent harm, they further stated there was nothing broken, the resident just needed sutures. During an interview on 11/21/2024 at 1:41 PM Certified Nurse Aide #26 stated if a resident is a 2-person assist, they need to be transferred with 2 staff members. The transfer should not be completed with 1 person. 10 NYCRR 415.12(h)(1)

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	335845	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northeast Ctr for Rehabilitation and Brain Injury	300 Grant Avenue Lake Katrine, NY 12449

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the recertification and abbreviated (NY00340876) survey from 11/13/2024 to 11/21/2024, the facility did not ensure a resident's total program of care, including medications and treatments, were reviewed at each visit. This was evident for 1 (Resident #677) of 41 total sampled residents. Specifically, Nurse Practitioner #1 did not review and ensure the accuracy of transcribed medication orders upon Resident #677's admission to the facility. The findings are: The facility policy titled Admission/Readmission of the Resident Neighbor dated 5/2024 documented licensed staff verified orders with the Physician, transcribed orders, and filled out other diagnostic test slips. Resident #677 had diagnoses of bipolar disorder and mononeuropathy (a type of nerve damage). The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #677 was moderately cognitively impaired, did not receive pain medication, and received antipsychotic medication. The Hospital Discharge Instructions dated 4/10/2024 documented Resident #677 was to receive Gabapentin 100 milligrams once daily in the morning before breakfast, Gabapentin 400 milligrams once daily in the evening, Divalproex sodium 2000 milligrams once daily in the evening. and Quetiapine (Seroquel) 100 milligrams once daily in the evening. The Nursing Note dated 4/10/2024 documented Resident #677 was admitted to the facility from the hospital following a syncopal episode at home, the Nurse Practitioner would assess, and the orders were placed. The Nurse Practitioner Note dated 4/10/2024 and the Physician Orders dated 4/10/2024 documented Resident #677 was to receive Divalproex sodium 2000 milligrams daily at 9 AM for bipolar disorder, Seroquel 100 milligrams daily at 9 AM for bipolar disorder, Gabapentin 400 milligrams daily at 9 AM for mononeuropathy, and Gabapentin 100 milligrams daily at 9 AM for mononeuropathy. The Medication Administration Record for April 2024 documented Resident #677 was administered and received Divalproex sodium 2000 milligrams daily at 9 AM, Seroquel 100 milligrams daily at 9 AM, Gabapentin 400 milligrams daily at 9 AM, and Gabapentin 100 milligrams daily at 9 AM from 4/10/2024 to 4/20/2024. A Nursing Note dated 4/20/2024 documented Resident #677's orders for Gabapentin 400 mg and Seroquel 100 mg were changed from 9 AM to 9 PM after the resident's family member alerted Nurse Practitioner #1 that Resident #677's medications were incorrectly reconciled upon their admission to the facility on [DATE]. There was no documented evidence Nurse Practitioner #1 reviewed Resident #677's admission medication orders to ensure accurate transcription and administration. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 02:49 PM, Assistant Director of Nursing #2 was interviewed and stated the admitting nurse was responsible for reviewing Hospital Discharge Instructions and transcribing orders for the facility's new admissions. On 11/21/2024 at 01:52 PM, Nurse Practitioner #1 was interviewed and stated they were called by the admitting nurses to reconcile medications and admission orders for newly admitted residents. Nurse Practitioner #1 stated they gave telephone orders for medications to the nurses and then reviewed and verified the telephone orders in writing during their next visit to the facility. Nurse Practitioner #1 stated they would not change a resident's medications from evening to morning administration time when reconciling a resident's admission orders. Nurse Practitioner #1 stated they review all hospital discharge paperwork including the Hospital Discharge Instructions when reconciling admission orders. Nurse Practitioner #1 stated someone did not transcribe Resident #677's admission medication orders for Seroquel and Gabapentin correctly. The mistake was fixed when the orders for Seroquel and Gabapentin were changed on 4/20/2024. Nurse Practitioner #1 stated they focus on dosage when signing off on transcribed admission medication orders because administration timing does not make as much of a difference as dosage of a medication. On 11/21/2024 at 01:11 PM, Physician #1 was interviewed and stated follow up consultations with outside physicians were ordered and arranged for newly admitted residents as recommended by the hospital discharge paperwork. 10 NYCRR 415.15(b)(2)(iii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47626 Based on interview and review of facility records during the recertification and abbreviated surveys (NY00348027, NY00343016, NY00357012) conducted from 11/13/24 through 11/21/24, the facility did not ensure consistent sufficient nursing staff was provided to meet the needs of residents on all shifts. Specifically, 1) Resident and family complaints received by the Department of Health reported the facility was short staffed, (F tag 677 for Resident #177 was cited as no showers were documented from 6/24/24-7/21/24), 2) Several nursing staff reported there was lack of staff to provide care to the residents, and 3 actual nursing staff sheets from 10/19/24 to 11/19/24 showed on multiple occasions the facility was below the projected levels documented on the Facility Assessment. Findings include: The Facility Assessment documented projected staff needs for nurses: Day shift 14, Evening shift 14, Night shift 12, and Certified Nurse Aides Day shift 26, Evening shift 24, and Night shift 16. The Facility staffing sheets from 10/19/24-11/19/24 and the Facility Assessment, for residents to direct care nursing staff documented the actual staffing for 32 of 32 days reviewed was less than the projected staffing needs based on the Facility Assessment with consistent understaffing on both the Vent and NRP5 units. During an interview on 11/20/24 at 9:00AM, Resident #473's family member stated the resident told them staff had told them to hold their urine for 2 hours. When the family member spoke with the nurse at that time, they were told they only had 2 certified nurse aides so the resident needed to wait because the staff could only do rounds every 2 hours. During an interview on 11/19/24 at 9:16 AM the Staffing Coordinator stated there were some days that actual staffing levels did not meet the projected levels as defined in the Facility Assessment. They stated they completed the schedules, and then the schedules were reviewed by the Director of Nursing and Assistant Directors of Nursing. They stated short staffing could affect resident care and stated on the vent unit each resident needs 2 staff for care. They stated staff have complained about low staffing. During an interview on 11/20/24 at 3:11 PM the Registered Nurse Unit Manager on the NRP5 unit, after reviewing the Activities of Daily Living documentation for Resident #177, stated they find it hard to believe the resident did not get a shower for over a month. They stated they believe the staff did not document because of low staffing. During an interview on 11/20/24 at 4:30 PM Certified Nurse Aide #11 stated staffing is hard. They stated they are supposed to have 4 Certified Nurse Aides and the day prior they only had 2 Certified Nurse Aides. They stated they usually had 3 Certified Nurse Aides, but at times, they have only 1 Certified Nurse Aide. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 9:32 AM the Director of Nursing stated they have worked hard to maintain staffing, using agency and have a corporate recruiter. They stated staffing is based on projected staffing levels, census, and acuity. They stated the Nurse Management Team has worked with the staffing coordinator to ensure they have staff, but because of location and population staffing has been difficult. They stated at times they are below the projected staffing level. During an interview on 11/20/24 at 9:39 AM the Administrator stated they staff the building based on projected staffing levels as defined in the Facility Assessment. They stated the Director of Nursing, working with the Staffing Coordinator are responsible to ensure staffing. They stated staffing has been a challenge and they do the best they can. 10NYCRR 415.13(A)(1) (i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 47626 Based on staff interviews and review of facility records during the recertification and abbreviated surveys (NY00348027, NY00343016, NY00357012) from 11/13/24 through 11/21/24, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, two of five randomly selected Certified Nurse Aides (#19, #20) did not have a performance review documented at least once every 12 months. Findings include: There was no documented evidence that performance reviews were completed in the last 12 months for Certified Nurse Aide (#19, and #20). During an interview on 11/19/24 at 2:44 PM, the Director of Human Resources stated they reviewed the requested personnel files and could not locate the performance reviews completed in the last 12 months for Certified Nurse Aide #19 and #20. They stated the unit manager was responsible for completing the performance reviews. They stated they send the unit managers a list of performance reviews that are due. They stated they monitor the completion by tracking the performance review completion dates on a spread sheet they created. Certified Nurse Aide #19 and #20 did not have a completion date on the tracking spread sheet. During an interview on 11/19/24 at 2:56 PM, Registered Nurse Unit Manager #5 stated they had not been trained to complete performance reviews. They stated they had never received a list of staff who were due for performance reviews. During an interview on 11/21/24 at 12:38 PM, the Director of Nursing stated the managers were responsible for completing the Certified Nurse Aide performance reviews and they did not realize they were not being completed. 10NYCRR 415.26 (c) (2) (iii)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on interview and record review conducted during the recertification and abbreviated (NY00340876) survey from 11/13/2024 to 11/21/2024, the facility did not ensure a resident received behavioral health services to attain their highest practicable well-being, in accordance with the comprehensive assessment and plan of care. This was evident for 1 (Resident #677) of 5 residents reviewed for Behavioral/Emotional Status out of 41 total sampled residents. Specifically, Resident #677 was diagnosed with a mental illness, received antipsychotic medication, and was not evaluated by a psychiatrist in accordance with a Physician Order. The findings are: The facility policy titled Behavior Intervention dated 10/2024 documented residents requiring staff intervention due to physical assault or aggression will be reviewed weekly by the Behavior Event Committee, including the Psychiatrist. Resident #677 had diagnoses of bipolar disorder and cognitive communication deficit. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #677 was moderately cognitively impaired and received antipsychotic medication. The Comprehensive Care Plan related to psychotropic drugs dated 4/10/2024 documented Resident #677 would remain free from psychotropic medication side effects and adverse reactions. The Comprehensive Care Plan related to mood dated 5/6/2024 documented Resident #677 displayed anxiety and would have a psychiatric consultation. The Nursing Note dated 4/10/2024 documented Resident #677 was admitted to the facility from the hospital, assessed by Nurse Practitioner #1, and orders were placed. Resident #677 presented with mild hand tremors and giggles a lot when asked any questions. There was no documentation related to Resident #677's diagnosis of bipolar disorder. The Nurse Practitioner Note dated 4/10/2024 and the Physician Orders dated 4/10/2024 documented Resident #677 was to receive Divalproex sodium 2000 milligrams daily at 9 AM for bipolar disorder, Seroquel 100 milligrams daily at 9 AM for bipolar disorder, and a psychiatry consult. The Nursing Note dated 4/20/2024 documented Resident #677's orders for Seroquel 100 mg were changed from 9 AM to 9 PM after the resident's family member alerted Nurse Practitioner #1 that Resident #677's medications were incorrectly reconciled upon their admission to the facility on [DATE]. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse Practitioner Note dated 5/10/2024 documented Resident #677 expressed anxiety and was taking her medication. Resident #677 needs a psychiatric evaluation. On 5/11/2024, the Nurse practitioner documented Resident #677 was evaluated on 4/5/2024 by neurology in the hospital for dementia. Resident #677 was unable to participate in the Mini-Mental Status Exam and it was unclear whether their responses were related to their bipolar disorder. Resident #677 was observed with hand tremors that were previously thought o be related to their use of Depakote medication. On 5/14/2024, the Nurse Practitioner documented Resident #677's Depakote level was noted to be high and Divalproex sodium was decreased. The Nurse Practitioner documented on 5/25/2024 that Resident #677 was hospitalized due to suspected COVID-19 infection. There was no documented evidence Resident #677 received a psychiatry consultation in accordance with the Nurse Practitioner's plan to address Resident #677's diagnosis of bipolar disorder and efficacy/side effects of antipsychotic medication. On 11/21/2024 at 01:52 PM, Nurse Practitioner #1 was interviewed and stated someone did not transcribe Resident #677's admission medication order for Seroquel. The mistake was fixed when the orders for Seroquel was changed on 4/20/2024. Nurse Practitioner #1 stated they ordered a psychiatry consult for Resident #677 upon their admission to the facility on [DATE]. The facility transitioned between psychiatry services, and this may be the reason Resident #677 was not evaluated by a psychiatrist. The facility did not have a psychiatrist visiting the facility around 5/2024 until the new Psychiatric Physician Assistant started with the facility. The new Psychiatry Physician Assistant visited the facility every 2 weeks and saw 10 patients each time they visited. The facility was backed up on obtaining psychiatric evaluation and consultations for residents because the census and number of residents referred for psychiatric consultations is greater than the 10 residents evaluated every other week. On 11/21/2024 at 01:11 PM, Physician #1 was interviewed and stated the facility recently changed their psychiatric services provider. The former psychiatrist provided approximately 20 hours a week to the facility to evaluate residents. The new Psychiatry Physician Assistant visits the facility, but the facility had far more residents than they could handle. The facility was looking into possible hiring an additional psychiatry provider on staff. 10 NYCRR 415.12(f)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51214 Based on observation, record review, and interview during the recertification survey from 11/13/24 to 11/21/24, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically, the facility did not ensure that an infection surveillance plan identifying symptom tracking of infection was implemented prior to the start of antibiotics for Resident #26 and #233. The findings are: The 10/4/24 Progress Notes for Resident #26 documented Urinalysis and Culture/Sensitivity ordered. The 10/7/24 Progress Note documented nursing was unable to obtain a urine sample due to the residents aggressive behavior when collection was attempted. Also noted, the family called to report urinary symptoms and irritation in the groin area. The 10/8/24 Physician Order documented start antibiotic on 10/9/24. The Line List for Antibiotic Use documented Resident #26 was started on antibiotic on 10/8/24, There was no documented evidence that symptom tracking was included on the Line List. The 10/18/24 Progress Notes for Resident #233 documented blood coming from the right ear, assessed by the Nurse Practitioner on 10/18/24. The 10/19/24 and 10/20/24 Progress Notes documented blood oozing from the right ear. The 10/23/24 Progress Note documented Resident #233 was seen by the Nurse Practitioner and started on antibiotic for purulent foul smelling drainage in the right ear. The Line List for Antibiotic Use documented Resident # 233 was started on antibiotics on 10/23/24. There was no documented evidence that symptom tracking was included on the Line List. During interview on 11/19/24 at 9:20 AM, the Assistant Director of Nursing #2/Infection Preventionist/Wound Care Nurse stated that antibiotic use is tracked on a line list and it is updated at the end of each month. They keep a binder of sheets with documentation for each resident currently taking an antibiotic until they transfer the information onto the Line List. They confirmed that the Line List is not a live list and is for antibiotic use only. Symptoms of infection are written on the unit specific 72 hour report sheets, but are not tracked on a line list or other facility wide document. 10NYCRR 415.19(a)(2)