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 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. 45478 Based on observation and staff interview during the recertification survey from 11/13/24 to 11/21/24, the facility did not ensure residents were provided with a dignified dining experience. Specifically, Certified Nurse Aide # 18 was observed standing while feeding 2 of 17 residents (Resident #42 and #239) reviewed for dining, The finding is: On 11/18/24 at 12:05 PM, Certified Nurse Aide #18 was observed standing while feeding Resident #42 their lunch meal. During observation Certified Nurse Aide #18 was directed to sit down by another staff and stated prior to sitting, Oh my back was hurting and I'm short. On 11/18/24 at 12:36 PM Certified Nurse Aide #18 was observed standing while feeding Resident #239. During an interview on 11/19/24 at 12:39 PM, Certified Nurse Aide #18 stated they forgot about sitting down when feeding the residents. 10 NYCRR 415.5(a)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214 Based on record review and interview during the recertification survey from 11/13/24 to 11/21/24, the facility did not ensure residents and/or their designated representative were fully informed of their right to an expedited review of a service termination. Specifically, for two of three residents (Resident #8 and #104) reviewed for Beneficiary Protection the facility did not ensure the Notice of Medicare Non-coverage form CMS-10123 was provided to the resident and/or representative at a minimum of two days prior to the end of Medicare Part A covered services. The findings are: The undated Facility Policy titled Notice of Medicare Non-Coverage documented when a resident is no longer eligible for skilled coverage under Medicare Part A, the facility must issue a Notice of Medicare Non-Coverage to the resident or their legal representative with a minimum notice of two days. If the resident is incompetent deliver the Notice of Medicare Non-Coverage to the resident's legal representative. You must notify them in person if available or via phone. Document the representative's name, phone number, date and time you spoke with them and send certified mail on the same day you spoke with them. The Comprehensive Minimum Data Set, dated dated dated [DATE] documented Resident #8 had cognitive impairment. The Interdisciplinary Team Note dated 7/30/24, documented Rehabilitation Assistant #14 spoke with the Administrator regarding Resident #8' Medicare Part A coverage and their right to appeal. The Notice of Medicare Non Coverage signed on 7/30/24 by the Administrator documented rehabilitative service ended on 7/23/24 and the last day of covered services will be 8/2/24. There was no documented evidence that the Notice of Medicare Non Coverage was provided to the designated representative/contact person. The Comprehensive Minimum Data Set, dated dated dated [DATE] documented Resident #104 had cognitive impairment. The Interdisciplinary Team Note dated 10/29/24, documented Rehabilitation Assistant #14 spoke with the Administrator regarding Resident #104's Medicare Part A coverage and their right to appeal. The Notice of Medicare Non Coverage signed on 10/29/24 by the Administrator documented rehabilitative service ended on 9/19/24 and the last day of covered services will be 11/1/24. There was no documented evidence that the Notice of Medicare Non Coverage was provided to the designated representative. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 12:04 PM Rehabilitation Assistant #14 stated they determine who they have to contact regarding Notice of Medicare Non Coverage based on the resident's capacity and they would discuss with the Social Worker and/or if they should contact the resident representative. They stated they will call the representative if listed, leave a message if unable to reach them, and then send the Notice of Medicare Non Coverage to the designated representative. They stated if unable to reach the representative, the Administrator may sign the Notice of Medicare Non Coverage for the resident. They stated they would document why they had the Administrator sign the notice. They stated for Resident # 8, they tried but were unable to reach the family and did not document the attempted contact on the notice. They stated for Resident #104, the resident's parents passed away, and another family member told the Social Worker they did not want to be involved with anything financial. They stated the Social Worker told them to give the Notice of Medicare Non Coverage to the Administrator for signature. They stated no calls were made for this resident regarding Medicare coverage. During an interview on 11/18/24 at 1:30 PM the Administrator stated Rehabilitation Assistant #14 brings the Notice of Medicare Non Coverage to them if the resident has cognitive impairment/limited capacity/no representative or they are unable to reach the representative. They stated for Resident #8, Rehabilitation Assistant #14 attempted to call the family but was unsuccessful, so they brought the Notification of Medicare Non Coverage to them for signature. When asked about resident #104, the Administrator stated they would have to ask the Social Worker about the resident contacts. The Administrator stated they would expect Rehabilitation Assistant #14 to check on the resident status, capacity, family/representative, before coming to them for a signature. The Administrator stated neither Resident #8 or #104 had the capacity to sign the Notice of Medicare Non Coverage. They stated the expectation would be for the Rehabilitation Assistant to document the attempt made when trying to contact the family. They stated Notice of Medicare Non Coverage are typically sent to the family in addition to a phone call, but in these cases they were not sent because they were signed by the Administrator. They stated it is rare for the Administrator to receive the Notification of Medicare Non Coverage to sign, but does happen at times. 10 NYCRR 415.3 (g)

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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. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 47626 Based on observation, interview, and record review conducted during the Recertification Survey from 11/13/2024 to 11/21/2024, for one (Resident #208) of ten residents reviewed for nutrition, the facility did not ensure services were provided to maintain acceptable parameters of nutritional status. Specifically, for Resident #208, weight measurements were not obtained timely as per physician order when a significant change in weight occurred. The findings are: Resident # 208 had diagnoses including Cerebral Infarction, Acute Respiratory Failure, and Type 2 Diabetes. The Physician orders dated 10/24/24 documented weigh on admission, weekly weights from 10/24/24-11/14/24, then monthly weights. The 10/24/24 weight documented Resident #208 was 183 lbs. The 10/30/24 Admission Minimum Data Set (an assessment tool) documented Resident #208 had severely impaired cognition, was dependent with all activities of daily living and had no weight loss. The 11/1/24 weight documented Resident #208 was 181.2 lbs. The 11/7/24 weight documented Resident #208 was 166.0 lbs. (This was a 9.29% weight loss). The Care Plan titled Gastric-Tube updated on 11/7/24 documented Gastric-tube feeding Jevity 1.5 at 75 milliliters/hour, turn feeding on at 4 PM, turn feeding off at 10AM, total calories 2,025 delivered. There was no documented evidence of weights documented for Resident #208 between 11/7/24 and 11/19/24. The 11/19/24 weight documented Resident #208 was 164.4 lbs. During an interview on 11/19/24 at 11:40 AM the Dietician stated when Resident #208 came to the facility, they followed the hospital order for Jevity 1.5 at 55 milliliters per hour continuous. On 11/6/24 they adjusted Resident #208's tube feeding to Jevity 1.5 milliliters to be administered between 4PM-10AM. Caloric intake for Resident #208 was 1980 calories originally and is currently 2025 calories. They stated the physician was notified notified of the weight loss and weekly weights were reordered on 11/14/24. They stated a weigh now order was placed on 11/14/24 but no new weight was available for that time. During an interview on 11/18 /24 at 3:20 PM Registered Nurse Unit Manager (Ventilator unit) stated the weigh now order was placed on 11/14/24 but was never done. They stated the order written would have had an automatic stop and whether it was completed or not, would no longer be valid after 24 hours. They stated they did not know why the weight was not done on 11/14/24 as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 11:08 AM the Director of Nursing stated when a resident has weight loss, they discuss it with the dietician, and they will make recommendations regarding formula type/rate to the physician. They stated they should have weighed the resident on 11/14/24 when the weigh now order was placed and did not know why it was not done. During an interview on 11/20/24 at 2:29 PM Physician #1 stated the resident should have been weighed weekly for the first four weeks. They stated when the resident had a noted weight loss a weigh now order was placed. They stated they were unaware the weight was not obtained. 10 NYCRR 415.12(i)(1)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51214 Based on observation, interview, and record review conducted during a recertification survey from 11/13/24-11/21/24, the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards for expiration dates. Specifically, expired medications and a Lantus Insulin Pen not discarded after 28 days of being open were found in one of the five medication storage rooms and one of eight medication carts (Vent Unit) observed for medication storage. Additionally, one medication refrigerator behind a locked door containing Lorazepam (a controlled substance) was not secured to a permanent fixture in the room. The findings are: The facility policy titled Medication Storage dated 11/1/2013, revised 6/2024, documented resident medications will be stored in a manner that maintains the integrity of the product, ensures the safety of the residents and is in accordance with Department of Health Guidelines. All medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy, and expired, discontinued and/or contaminated medications will be removed from the storage areas and disposed of in accordance with facility policy. During an observation on 11/14/24 at 10:31 AM of the south medication room on the Vent Unit, the refrigerator behind a locked door, containing 4 vials of Lorazepam (expiration date 11/2024) was not secured to a permanent fixture in the room. During an observation on 11/14/24 at 11:05 AM of the north medication room on the Vent Unit, two unopened bottles of Vitamin D 25 mcg with expiration dates of 7/24 and 9/24, and one unopened bottle of Vitamin B-6 100 mg had an expiration date of 10/24. In the north medication room refrigerator there was a Lantus Insulin Pen with an open on date of 9/24/24. During an interview on 11/14/24 at 11:15 AM Licensed Practical Nurse #16 stated the insulin should be discarded once open after 28 days. They also stated the nurses should check the over the counter medication expiration dates prior to taking them from the closet and before opening for use. They stated each nurse administering medication is responsible for checking the expiration dates. During an observation on 11/14/24 at 11:50 AM of a medication cart on the MCU Unit, there was one open bottle of Fish Oil 500 mg with an expiration date of 9/2024 in the cart. During an interview on 11/14/24 at 12:00 PM Licensed Practical Nurse Unit Manager #3 stated the floor nurses should check the medication carts and medication room on the unit. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/24 at 1:09 PM the Director of Nursing stated that unit medication rooms and carts should be checked by the floor nurses on the overnight shift and by Unit Managers. They stated they, the Director of Nursing, do spot checks of the medication storage rooms and medication carts as well to assure there are no expired medications and that items are bagged appropriately. They stated the unit refrigerators are not bolted to the floor or another permanent fixture in the medication storage rooms. During an interview on 11/21/24 at 11:09 AM the Pharmacy Consultant stated that the pharmacy does check the facility medication carts as a courtesy to the facility on a quarterly basis, but it is really the facility's responsibility They stated Central Supply is also supposed to check for expired medications. 10 NYCRR 415.18

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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)