STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335857	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilkinson Residential Health Care Facility	4988 State Hwy 30 Amsterdam, NY 12010

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification and abbreviated survey (Case #s NY00343349, NY00344172, NY00345225, and NY00379263), the facility did not ensure the resident's right to be free from abuse and neglect for three (3) (Resident #s 40, 44, and 53) of eight (8) residents reviewed for abuse and neglect. Specifically, (a.) on 6/02/2024, Resident #40 was left unattended outside of the facility by Certified Nurse Aide #7 for an extended period of time; (b.) on 6/12/2024, Certified Nurse Aide #8 did not follow Resident #44's care plan to use a mechanical lift which resulted in an injury to the residents foot; (c) on 5/27/2025, Certified Nurse Aides #'s 5 and 6 did not provide personal care to Resident #53 the way the resident preferred, causing Resident #53 to fight against the care, sustaining a bruise to their hand. This is evidenced by: The facility policy titled, 'Resident Abuse Prevention,' dated 5/2023, documented that the purpose was to provide residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The policy documented that the facility shall identify, correct, and intervene in situations in which abuse, neglect, mistreatment, or misappropriation of property may be more likely to occur. Procedures documented included, but were not limited to, supervision of staff shall include identification of inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, or directing residents in need of toileting to urinate or defecate in their beds or briefs, and counseled when performance is not acceptable. Resident #40 Resident #40 was admitted to the facility with Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavior), dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #40 usually made themselves understood, sometimes understand others, and had severe cognitive impairment. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan, dated 11/20/2023, documented that the resident was at risk for elopement related to impaired cognition and verbalized their desire to leave the facility. Resident #40 had cognitive impairment with poor decision-making skills and/or pertinent diagnoses such as dementia and Alzheimer's. The Comprehensive Care Plan documented the following interventions implemented on 6/03/2024 for safety awareness: the resident would not be left unsupervised when off the unit, including when outside of the building. The facility's Investigative Report dated 6/05/2024 documented that Resident #40 was brought outside by Certified Nurse Aide #7 and was left outside the facility's front entrance unattended from 2:12 PM to 3:50 PM on 6/02/2024, at which time they were brought back in by a visitor. A statement in the investigation from Licensed Practical Nurse #10 documented that the resident repeatedly asked to go outside and Certified Nurse Aide #7 offered to take them. Licensed Practical Nurse #10's statement documented that they expected them to remain outside together, but did not see t Certified Nurse Aide #7 again because it was the end of the shift. The statement from Certified Nurse Aide #7 documented that they thought there was an activity happening because there were multiple people outside at the time. The resident was assessed upon entrance back into the facility by a Registered Nurse and was found to have no psychological or physical harm. During an interview on 5/22/2025 at 3:35 PM, Certified Nurse Aide #7 stated that they were asked to bring Resident #40 outside as they expressed interest in getting some fresh air. They stated that upon bringing the resident outside, they noticed a large group of residents and assumed that there was a group activity going on, and left the resident with the group. Certified Nurse Aide #7 stated that they would never have left the resident alone if they knew that there was no activity being done. During an interview on 5/23/2025 at 10:25 AM, Registered Nurse #3 stated that they remembered the incident. They stated that Certified Nurse Aide #7 was very good at taking care of the residents. They stated that they believed it was a misunderstanding of the circumstances and that they would have never left the resident outside alone if they knew that there was no activity being done. They stated that they have never had any issues with Certified Nurse Aide #7 in providing resident care. During an interview on 5/23/2025 at 11:30 AM, Director of Nursing #1 stated that they were the director at the time of the incident and did remember the incident. They stated that it was the weekend, and a Licensed Practical Nurse # 10 asked Certified Nurse Aide #7 to bring the resident outside and the resident was left with a group of residents who were already outside. They stated the Certified Nurse Aide #7 misunderstood that there was an activity being performed and left the resident with the group. They stated another resident's family member brought the resident back inside, realizing they were outside alone. They stated that the resident was assessed for injuries, and none were found. They stated the Certified Nurse Aide was disciplined and reeducated on the policies for taking a resident outside of the facility. Director of Nursing #1 stated there was facility-wide education on the policies of signing residents in and out of the floor, resident head count, and wandering and eloping. Resident #44 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #44 was admitted to the facility with left-sided hemiplegia and hemiparesis following cerebral infarct (paralysis and inability to use extremities due to symptoms from having a stroke), chronic respiratory failure with hypoxia (a condition where the lungs struggle to provide enough oxygen to the blood, leading to low oxygen levels in the body); and chronic congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively to meet the body's needs). The Minimum Data Set, dated [DATE], documented that the resident could be understood, usually understand others, and had intact cognition for daily living decisions. A review of progress notes dated 6/13/2024 at 9:25 AM, documented Registered Nurse #2 witnessed the resident sitting on the edge of their bed, eating breakfast, complaining of pain in their left ankle/foot. They documented that the resident's foot was red, warm, and swollen. They also documented a bruise on the outside of their foot from mid-foot to heel. Registered Nurse #2 documented that the Medical Director #1 ordered an X-ray for the resident. A review of the Facility Reported Incident dated 6/17/2024, documented that the resident was injured when Certified Nurse Aide #8, who was caring for them, did not use the required mechanical lift as directed in the resident's care plan and care card. During an interview on 5/19/2025 at 12:07 PM, Resident #40 stated that they remembered the incident and stated that the Certified Nurse Aide who took care of them did not use the mechanical lift they were supposed to, and their foot got caught under the bed. They stated they only had the Certified Nurse Aide a couple of times and that they never used the lift, but all the other aides did. During an interview on 5/21/2025 at 11:45 AM, Registered Nurse #2 stated that they remembered the incident. They stated Certified Nurse Aide #8 did not use the lift when they transferred Resident #44 into bed. They stated that the resident's care card documented to use an Mechanical-1 lift device when transferring the resident. They stated that during the facility incident investigation, Certified Nurse Aide #8 admitted that they did not follow the resident's care card and transferred the resident by themselves. The Certified Nurse Aide thought they were able to transfer the resident by themselves and did not get the lift. Registered Nurse #2 stated that the aide was terminated that day for not following the care card, which resulted in injury to the resident. Registered Nurse #2 stated they interviewed other residents regarding the Certified Nurse Aide and there were no other reports made that the staff were not using the appropriate devices for transferring. They stated that care plans should reflect the resident's needs. During an interview on 5/23/2025 at 11:30 AM, Director of Nursing #1 stated that they were the director at the time of the incident and did remember the incident. They stated the Certified Nurse Aide at the time of care did not follow the care card for the resident, which resulted in injury. They stated that the Certified Nurse Aide was from an agency and was terminated from employment after the incident due to not following the resident's care plan. They stated that there was no facility-wide education as there were no other incidents, and the Certified Nurse Aide was terminated that same day. Resident #53 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #53 was admitted to the facility with the diagnoses of hypertensive heart disease (high blood pressure), chronic kidney disease with heart failure (chronic kidney damage due to uncontrolled high blood pressure), and type 2 diabetes mellitus (an endocrine dysfunction causing issues with insulin production). The Minimum Data Set, dated [DATE], documented that the resident could usually be understood, usually understand others, and was slightly cognitively compromised. The Comprehensive Care Plan for behaviors initiated 10/09/2023 documented that the resident had socially inappropriate/disruptive behavioral symptoms as evidenced by yelling at staff and refusal of medications/treatments. Approaches documented included allowing the resident to have control over situations, if possible. An evaluation note dated 5/28/2024, documented the incident with Certified Nurse Aides #5 and #6, and that Resident #53 would see psychology and social work for several weeks, but was not showing negative psychological signs from the event. The Facility Investigation dated 5/27/2024 documented Resident #53 reported that Certified Nurse Aide #5 and Certified Nurse Aide #6 did not provide personal care to Resident #53 the way the resident preferred, which caused Resident #53 to fight against the care, and sustained a bruise to their hand. Resident #53 stated that the Certified Nurse Aides flipped the resident around in the bed and shoved them. Both Certified Nurse Aides were suspended while the investigation was performed. Follow up to the investigation documented that the Certified Nurse Aides had not given Resident #53 their evening care in the manner they preferred. This caused the resident to act out/fight during care and the resident hit their hand on the side rail. During an interview on 5/22/2025 at 10:45 AM, Certified Nurse Aide #3 stated that if a new injury was discovered, they would tell the Licensed Practical Nurse or Registered Nurse on the unit. They were supposed to look at the injury, write statements, assess the injury, and determine how it happened. Certified Nurse Aide #3 stated they would report any abuse or mistreatment they saw or heard about. During an interview on 5/27/2025 at 9:18 AM, Director of Nursing #1 stated that the Resident #53 was very particular about their care and was very verbally abusive with the staff at times. Certified Nurse Aides #s 5 and 6 were spoken to about the incident when it occurred. Director of Nursing #1 stated that they had not heard of Resident #53 having any problems for a while, so they believed the resident was settling in and things were good. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during a recertification and abbreviated survey (Case #NY00358788), the facility did not ensure that all allegations of abuse were thoroughly investigated for one (1) (Resident #359) of eight (8) residents reviewed for abuse. Specifically, Resident #359 reported an allegation of verbal/metal abuse and rough treatment during care given on the evening shift of 10/25/2024 by five (5) facility staff during an insertion of an indwelling Foley Catheter. The facility initiated an investigation on 10/28/2024, and did not determine where a bruise of unknown origin occurred and did not investigate the source of the bruise until 10/30/2024. This is evidenced by: Cross reference with F-684. The facility's policy and procedure titled 'Resident Abuse Prevention' dated 5/2023, documented staff shall report any unusual changes in residents' condition promptly so that occurrences, patterns, or trends that constitute abuse can be identified, such as suspicious bruising, change in demeanor, or withdrawal. The abuse policy did not address the process for investigation after an alleged allegation of abuse was made. Resident #359 was admitted to the facility with diagnoses of status post spinal surgery for a pathological compression fracture (a broken bone caused by underlying disease, diabetes mellitus (a disorder where the body does not produce enough insulin and the person has consistently high blood sugar), and morbid obesity (too much body fat which increases the risk of health problems). The Minimum Data Set (an assessment tool) dated 10/25/2024, documented the resident could be understood, and understand others, and had intact cognition for daily decision making. Record review demonstrated Resident #359 returned from the hospital on [DATE]. A facility investigation summary documented the following: Investigation was started on 10/28/2024 at 8:00 AM. The report documented Resident #359 reported an allegation of abuse that occurred on 10/25/2024 during the evening shift. Resident #359 alleged 5 staff members held them down to catheterize the resident. The resident reported the incident to Registered Nurse #1 on 10/28/2024 at 7:30 AM. Resident #359 stated staff had been both verbally and physical abusive. Registered Nurse #1 notified Director of Nursing #1 and Director of Social Work #1 who began an investigation and notified the New York State Department of Health reporting division of the alleged abuse per regulation. Investigation on 10/28/2024 did not address bruising on upper left arm with staff until 10/30/2024. The investigation did not address why Licensed Practical Nurse #2 did not call for assistance from Registered Nurse Supervisor #1 or why neither nurse had notified Director of Nursing #1 of the events that occurred on 10/25/2024. During an interview on 5/23/2025 at 3:00 PM, Director of Nursing #1 stated they were not made aware of the difficulty that occurred during the catheterization of Resident #359 on 10/25/2024 until the morning of 10/28/2024. An investigation was started to determine what had occurred. Director of Nursing #1 stated the investigation was not completed when it was first reported to the Department of Health. Some things were missed during the investigation and the bruise found on the resident arm had not been investigated thoroughly. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 3:15 PM, Administrator #1 stated after review of the 'Resident Abuse Policy,' the policy would need to be updated because it did not address the investigation process that should occur when an allegation of abuse was made. 10 New York Code of Rules and Regulations 415.4(b)(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** Based on record review and interview conducted during the recertification and abbreviated survey (Case #NY00358788), the facility did not ensure residents received appropriate care and treatment in accordance with professional standards of practice to maintain or improve their physical, mental, and psychosocial well-being for 1 (one) (Resident #359) of 1 (one) resident reviewed. Specifically, for Resident #359, Licensed Practical Nurse #2 did not notify the facility health care practitioner after the resident had a mental status change and became resistant to care during a physician ordered health care procedure on 10/25/2024. Furthermore, a Registered Nurse did not document or assess Resident #359 when a procedure was ordered and mental status change occurred. There was no documented evidence that a Registered Nurse completed a follow up assessment during an ordered procedure that required assessment, nor that a report was given to the oncoming Registered Nurse prior to outgoing Registered Nurse leaving the facility at the end of their shift. The facility did not monitor resident responses to the intervention of the health care procedure or recognize or assess the risk factors placing the resident at risk for psychosocial harm. This is evidenced by: Cross reference with F-610, F-726 A review of the policy titled, Change in Condition dated 2/2020 documented that the attending physician would be notified immediately as indicated by the significance of the change and need for medical intervention. Resident #359 Resident #359 was admitted to the facility with diagnoses of status post spinal surgery for a pathological compression fracture (a broken bone caused by underlying disease), diabetes mellitus (a disorder where the body does not produce enough insulin and the person has consistently high blood sugar), and morbid obesity (too much body fat which increases the risk of health problems). The Minimum Data Set (an assessment tool) dated 10/25/2024, documented the resident could be understood, was able to understand others and was cognitively intact to make daily decisions. Review of a facility reported incident (Case # NY00358788) received by the New York State Department of Health on 10/29/2025 documented the following intake: On 10/28/2025, Resident #359 voiced concerns to Registered Nurse #1 regarding interactions with staff on date of their readmission from the hospital on [DATE]. Per the resident, five (5) staff members held them down while inserting a catheter. Upon review of nursing notes, resident did have catheter insertion due to bladder scan which revealed 804 cubic centimeters (equivalent to millimeters). Review of 24-hour office report, staff had documented kicking and screaming during foley insertion. The facility's immediate response and plan to prevent recurrence, including any change in policy / procedure and action taken in regard to staff included the social worker to interview the resident to determine resident psychological impact, and two (2) caregivers to be present at all times during care pending outcome of investigation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility investigation report dated 10/28/2024 at 8:30 AM, documented that Resident #359 had returned from the hospital on [DATE] and had an episode of apnea and was unresponsive, physician was notified. A bladder scan was ordered, with placement of a foley catheter if the residual was over 400 milliliters. The resident was intermittently confused and resistive when staff attempted to catheterize them. Resident #359 ' s change of mentation was not reported to the physician to determine if the staff should have attempted further care or if different treatment was necessary. No documentation of the catheterization incident had been completed by Licensed Practical Nurse #2 or Registered Nurse Supervisor #1 until after the resident reported abuse by staff on 10/28/2025. A review of personal written statement by Certified Nurse Aide #2, located within the facility investigation report dated 10/28/2024, documented that at about 10:00 PM on 10/25/2025, Licensed Practical Nurse #2 asked them to help hold Resident #359 ' s legs so they could insert a catheter. They said yes, went to the room, let the resident know what they were doing; Resident # 359 was very tired still and stated that. Upon trying to complete the catheterization, Resident #359 kicked a few times so they went to get help, and three (3) additional staff came in. Two (2) staff were holding the resident ' s left leg, and two (2) staff (they believe) were holding the resident ' s right leg, while Licensed Practical Nurse #2 was attempting to insert the catheter. Certified Nurse Aide #2 documented that when Licensed Practical Nurse #2 couldn ' t insert the catheter, Licensed Practical Nurse #3 stepped in to help and successfully completed the health care procedure. A review of personal written statement by Social Worker #1, located within the facility investigation report dated 10/28/2024, documented that Social Worker #1 interviewed Resident #359 on 10/28/2024 at 8:26 AM regarding the resident ' s report. Social Worker #1 wrote that Resident #359 stated the following about the incident: they were ' assaulted by five (5) nursing staff when they told them they were going to put the catheter in and Resident #359 said no because their body just had it; ' that they asked to be woken up and placed on a bed pan; that the staff held Resident #359 down and forcibly put the catheter in; that Resident #359 was ' screaming ' for Registered Nurse Supervisor #1; that there were at least five (5) staff in the room; that Resident #359 was screaming and kicking when a staff member stated ' oh my god you need to stop; ' that Resident #359 felt that ' it was so traumatic, violently because the resident was trying to kick; it was bringing up a lot of childhood trauma; ' that the resident stated ' they could have sat me down and explained--there were so many alternatives that could have happened. ' Social Worker #1 documented that during the incident, when asked where each of the staff were standing and doing, Resident #359 stated that each staffer held a limb and one (1) was leaning over their mid section. A nursing progress note dated 10/25/2024 at 8:40 PM, written by Registered Nurse Supervisor #1 documented Resident #359 was readmitted today. Had 10 to 15 seconds of apnea with snoring respirations. Vital signs: Temperature 98.7, Pulse 106, Respirations 22, Oxygen saturation 96 percent on room air. Oxygen dropped to 92 percent with apnea. Lungs diminished throughout, oxygen at 2 liters via nasal canula placed on resident due to apnea. Pale in color. Apical Pulse regular but tachycardic (fast heartbeat), blood sugar 110. Physician made aware and order obtained to send to emergency room. Emergency Medical Services notified. A nursing progress note dated 10/25/2024 at 9:31 PM, written by Registered Nurse Supervisor #1 documented Resident #359 became responsive when Emergency Medical Services arrived. Answering questions appropriately. Still mumbling words. Resident refused medical transport to emergency room even though medical emergency services recommended. Physician made aware of refusal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 10/25/2024 at 10:19 PM, written by Licensed Practical Nurse #2 documented the resident confused this evening. Refused 9:00 PM medications. Registered Nurse Supervisor #1 administered intravenous medication and resident was not responsive. Vital signs: Temperature 98.7, Pulse 106, Respirations 22, Oxygen saturation 96 percent on room air. Frequent apnea. Physician okayed to sending resident to emergency room. Ambulance arrived and resident decided stay in nursing home; vital signs became stable. Physician ordered bladder scan with anything over 400 milliliters insert foley. Result was 804 millimeters of urine retained. Urine for culture obtained. Resident in bed. Continue plan of care. There was no documented evidence that the physician was notified of the results from catheterization. A nursing progress note dated 10/26/2024 at 6:30 AM written by Licensed Practical Nurse #3 documented Resident #359 alert with confusion. Resident had been sleeping in short to moderated intervals. Woke up yelling and confused unaware of where they were. Redirected. No complaints of pain offered Foley catheter output was 1250 milliliters. There was no documented evidence that the Resident #359 was assessed by a Registered Nurse, or physician notified regarding resident ' s confusion. A physician order dated 10/28/2024, documented Foley catheter to straight drainage #18 French catheter related to a diagnosis of obstructive uropathy. Special instructions: Change monthly and as needed. There was no documented evidence of physician ' s order for bladder scan or foley on 10/25/2024. Review of nursing progress notes from 10/25/2024 through 10/31/2025 did not document notification to the physician of difficulty with the ordered catheterization (placement of an indwelling catheter to eliminate urine from the bladder) or continued mental status changes that began on 10/25/2024 when the resident returned to the facility from a hospitalization. There was no documented evidence of vital signs after the procedure on 10/25/2024 through 10/26/2024. No Registered Nurse assessment or addition of a comprehensive care plan for urinary retention was found from 10/25/2024 through 10/26/2024. A comprehensive care plan for mental status changes was not added to the resident ' s care with goals and interventions until 10/28/2025 after abuse allegations were made by Resident #359. A review of the corrective action report dated 10/28/2024 conducted by Director of Nursing #1 documented that all five (5) staff involved in the catheterization of Resident #359 were educated on the proper way to perform a procedure if a resident was confused or refusing care. It was further noted that the Health Care Provider was never notified of Resident #359 ' s change in mentation after the physician ordered a bladder scan and insertion of the foley catheter. It was also noted that when the resident initially refused the procedure, the physician should have been notified of the difficulty so other options could have been discussed. The Registered Nurse Supervisor #1 should have been notified, and Resident #359 should have been assessed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/27/2025 at 2:25 PM, Licensed Practical Nurse #3 stated they had catheterized Resident #359 when they arrived for the night shift. The resident was yelling and another nurse asked for assistance. Licensed Practical Nurse #3 stated they went to help because Licensed Practical Nurse #2 was unable to perform the insertion. Licensed Practical Nurse #3 stated they had not reviewed the order, and staff was trying to calm the resident, so Licensed Practical Nurse #3 took over and inserted the catheter without questioning what had taken place. The resident calmed after the foley was inserted. Licensed Practical Nurse #3 stated they were not aware if the physician was called or if any vital signs were completed after the catheter was inserted. Licensed Practical Nurse #3 stated the Registered Nurse Supervisor #1 had not returned to the floor and no further assessment was done by the Registered Nurse Supervisor that relieved them. Licensed Practical Nurse #3 stated staff was educated after the incident regarding policy and protocol that was not followed and care and treatment should not have been delivered the way it was. Professional standards of care had not been followed. A review of any order should be done before doing a procedure or administration of medication. If a resident was resistive to care or had mental status change, the physician should be notified before proceeding. The resident continued to be confused throughout the rest of the night. The physician was not notified that Licensed Practical Nurse #3 was aware of. During a telephone interview on 5/27/2025 at 1:35 PM, Registered Nurse Supervisor #1 stated they were notified Resident #359 had returned from the hospital on [DATE], had a period of apnea, and was unresponsive. After responding to the unit staff, 911 was called and the physician was notified. When Emergency Medical Services arrived, the resident was assessed and because they had become responsive by the time Emergency Medical Services arrived, Resident #359 had refused to go back to the hospital. The physician was notified of the resident ' s refusal, and an order was obtained to bladder scan the resident and catheterize them if urine residual was greater than 400 milliliters. Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #2 was assigned to the resident and was going to perform the catheterization. The resident was stable when Registered Nurse Supervisor #1 left the unit, and they were not aware of anything that had happened until the following day when they returned to the facility. The Registered Nurse Supervisor #1 stated Licensed Practical Nurses could not assess and when any change in condition occurred in a resident, they needed to notify the Registered Nurse on duty. Registered Nurse Supervisor #1 stated they were the only Registered Nurse in the building on evenings but had not checked back on the resident ' s condition prior to leaving for the night. They were unaware if any further vital signs were completed, or if any documentation had been placed on the 24-hour report about the resident ' s episode, refusal to go to the hospital, or the events surrounding Resident #359 ' s change in condition and subsequent catheterization. Registered Nurse Supervisor #1 stated they also did not give a shift report to the oncoming nurse and stated that they couldn ' t remember if there was an oncoming nurse at the time. (continued on next page)

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Wilkinson Residential Health Care Facility	4988 State Hwy 30 Amsterdam, NY 12010

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 2:52 PM, Registered Nurse #1 stated Resident #359 reported an accusation of verbal and physical abuse on 10/28/2024 when Registered Nurse #1 went in their room to perform a procedure. Registered Nurse #1 stated they notified Director of Nursing #1 and the Social Worker on 10/28/2025, and an investigation was started. They further stated that it was determined that no abuse occurred, however, the handling of the insertion of the catheter was not done per policy. If a resident was confused and refusing care, staff should have stopped and called the physician and the Registered Nurse on duty. That was not done. Registered Nurse Supervisor #1 did not notify the physician and did not return to the unit to ensure Resident #359 had been successfully catheterized. They stated no documentation was found on the 24-hour report. Registered Nurse #1 stated they were unaware there had been a concern with Resident #359 until they were told by the resident on 10/28/2024 at 7:30 AM. No evidence or documentation could be produced that Licensed Practical Nurse #2 had documented the events that occurred on 10/25/2024, or that the physician was contacted to report the difficulty that had occurred with the resident. They stated that staff were reeducated on proper ways to care for residents who were resistive to care and confused. During a telephone interview on 5/27/2025 at 12:45 PM, Medical Director #1 stated that they were notified on 10/25/2024 that Resident #359 was having an episode of unresponsiveness. The physician told the staff to send them out to the hospital. Staff contacted Emergency Medical Services to take the resident to the hospital. Medical Director #1 stated that after they were originally notified, staff called again, and stated the resident had become alert and had refused to go back to the hospital. Because the resident had just returned to the facility that day, and there was concern that the hospital had removed their foley prior to returning Resident #359 to the facility, the physician ordered a bladder scan to be done and if the results of the bladder scan was greater than 400 millimeters of residual urine, the staff would insert a foley catheter. The results of the bladder scan demonstrated Resident #359 had greater than 850 milliliters of urine and needed to be catheterized. The staff did not call the physician to inform them of the results of the bladder scan, the subsequent insertion of the foley catheter, or the difficulty the staff and resident experienced to carry out the order. Medical Director #1 stated that they did not receive notification of the resident ' s condition until 10/28/2024, 72 hours later when Director of Nursing #1 made them aware of the complications that had occurred. Medical Director #1 stated that the staff should have called and advised them of what had gone on. Registered Nurse Supervisor #1 should have reassessed the resident at the time and discussed the situation with them, so they could have collaboratively decided what would have been the best way to proceed with Resident #359 care and further interventions. During an interview on 5/22/2025 at 10:46 AM, Physician Assistant #1 stated they were notified on 10/28/2025 by Director of Nursing #1 of the allegation of abuse made by Resident #359. Physician Assistant #1 stated that resident was very sick and had experienced mental status changes on the day they returned from the hospital. When Physician Assistant #1 interviewed the resident, they did not remember the events of the day. Physician Assistant #1 stated that the physician should have been notified, and further assessment should have been completed when the resident was refusing to be catheterized. They stated that closer monitoring should have been done with vital signs and behavior monitoring over the weekend, so the provider could have made sure that the care and treatment for the resident could have been adjusted if it was required. (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 5/23/2025 at 3:00 PM, Director of Nursing #1 stated Registered Nurse Supervisor #1 had not reported any issue with Resident #359 and should have checked with the Licensed Practical Nurses prior to leaving for the night, given the fact the resident had an episode of unresponsiveness and mental status change. Director of Nursing #1 stated that a Registered Nurse was the only person that could assess residents, and Registered Nurse Supervisor #1 should have followed up or reported off to the oncoming Registered Nurse any concerns that occurred, especially with a resident who had been readmitted . Director of Nursing #1 stated that staff should have been in contact with the Registered Nurse #1 and the health care Provider throughout the whole event on 10/25/2024, given the difficulty during catheterization The allegation of abuse was unfounded, but all staff were reeducated on the policy of notifying the physician when a resident became resistive to care or confused or had any change of condition. They stated the situation was not handled per policy and the Registered Nurse, and the other staff did not follow professional standards of care. Multiple attempts (from 5/22/2025 to 5/28/2025) to interview Licensed Practical Nurse #2 were unsuccessful. 10 New York Codes and Rules and Regulations 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview conducted during a recertification and abbreviated (Case #NY00377111) survey , the facility did not ensure that resident environments were as free from accidents or hazards as was possible for three (3) (Resident #s 40, 44, and 358) of five (5) residents reviewed for accidents and hazards. Specifically, (a.) Resident #40, who was at risk for elopement and required supervision, was left alone outside unsupervised for 98 minutes on [DATE], and unable to get back into the building; (b.) an expired ointment medication was left on the Resident #44 ' s bedside table on [DATE], permitting access to the ointment by the resident or anyone that entered the room; and (c.) for Resident #358 - who was documented as someone who wandered with significant risk to themselves – was not adequately monitored when they wandered out of the facility to an adjacent building on [DATE]. This is evidenced by: The Wandering and Elopement Policy, last reviewed 6/2024, documented the facility was to ensure that systems, tools and processes were in place to prevent unsafe wandering and/or elopement and to ensure that actions were taken quickly and prudently by staff, should either occur. The procedures documented, in part, that an elopement risk assessment would be done on admission, the facility would assure the functionality of alarmed doors, and appropriate care planning implementation and revision. Resident #40 Resident #40 was admitted to the facility with Alzheimer ' s disease (a progressive brain disorder that primarily affects memory, thinking, and behavior), dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #40 usually made themselves understood, sometimes understand by others, and had severe cognitive impairment. The Comprehensive Care Plan dated [DATE], documented that the resident was at risk for elopement related to impaired cognition and verbalized their desire to leave the facility. Resident #40 had cognitive impairment with poor decision-making skills and/or pertinent diagnoses such as dementia and Alzheimer's. The Comprehensive Care Plan documented the following interventions implemented on [DATE] for safety awareness: the resident would not be left unsupervised when off the unit, including when outside of the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility ' s Investigative Report dated [DATE] documented that Resident #40 was brought outside by Certified Nurse Aide #7 and left outside the facility's front entrance unattended from 2:12 PM to 3:50 PM on [DATE], at which time they were brought back in by a visitor. A statement in the investigation from Licensed Practical Nurse #10 documented that the resident repeatedly asked to go outside and Certified Nurse Aide #7 offered to take them. Licensed Practical Nurse #10 ' s statement documented that they expected Certified Nurse Aide #7 and Resident #40 to remain outside together but did not see Certified Nurse Aide #7 again because it was the end of the shift. The statement from Certified Nurse Aide #7 documented that they thought there was an activity happening because there were multiple people outside at the time. The resident was assessed upon entrance back into the facility by a Registered Nurse and was found to have no psychological or physical harm. During an interview on [DATE] at 3:35 PM, Certified Nurse Aide #7 stated that they were asked to bring Resident #40 outside because they expressed interest in getting some fresh air. Certified Nurse Aide #7 stated that upon bringing the resident outside, they noticed a large group of residents gathered and assumed that there was a group activity going on and left the resident with the group, but Certified Nurse Aide #7 did not confirm with any staff present. Certified Nurse Aide #7 stated that they would never have left the resident alone if they knew that there was no activity being done. During an interview on [DATE] at 10:25 AM, Registered Nurse #3 stated that they remembered the incident. Registered Nurse #3 stated that Certified Nurse Aide #7 was very good at taking care of the residents. Registered Nurse #3 stated that they believed it was a misunderstanding of the circumstances and that Certified Nurse Aide #7 would have never left the resident outside alone if they knew that there was no activity being done. Registered Nurse #3 stated that they have never had any issues with Certified Nurse Aide #7 regarding providing resident care. During an interview on [DATE] at 11:30 AM, Director of Nursing #1 stated that they were the director at the time of the incident and did remember the incident. Director of Nursing #1 stated that it was the weekend, and a Licensed Practical Nurse asked Certified Nurse Aide #7 to bring Resident #40 outside and the resident was left with a group of residents who were already outside. They stated the Certified Nurse Aide misunderstood and thought there was an activity being performed and left the resident with the group. Director of Nursing #1 stated another resident's family member brought the resident back inside, after they realized the family were outside alone. They stated that the resident was assessed for injuries and none were found. They stated the Certified Nurse Aide #7 was disciplined and reeducated on the policies for taking a resident outside of the facility. Director of Nursing #1 stated there was facility-wide education on the policies of signing residents in and out of the floor, resident head count, wandering and eloping. Resident #44 Resident #44 was admitted to the facility with left-sided hemiplegia and hemiparesis following cerebral infarct (paralysis and inability to use extremities due to symptoms from having a stroke); chronic respiratory failure with hypoxia (a condition where the lungs struggle to provide enough oxygen to the blood, leading to low oxygen levels in the body); and chronic congestive heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively to meet the body's needs). The Minimum Data Set, dated [DATE], documented that the resident could be understood, usually understand others and had intact cognition for daily living decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 12:07 PM, Resident #44 had a medication canister ointment on their bedside table. The label for the medication read MICONAZOLE 1:1:1 OINT, and had an expiration date of [DATE]. During an interview on [DATE] at 12:07 PM, Resident #44 stated that the ointment had been there for quite some time and the nurses applied it to their left buttock area twice a day for a healed bed sore. They stated the nurses left the ointment on the table in their room. They stated that they had used the ointment that morning. During an interview on [DATE] at 12:33 PM, Registered Nurse #2 was shown the photograph of the medication and stated that it should not have been left at the resident ' s bedside. Registered Nurse #2 stated that the nurse most likely used the medication and forgot to put it away. When informed that Resident #44 stated the medication was always left in their room, Registered Nurse #2 stated that that was probably true, as Resident #44 was alert and oriented When shown the expiration date on the ointment, Registered Nurse #2 stated that it should not have been used. They stated that the resident was approved to self-medicate some medications, but the cream was not one of the medications Resident #44 was approved to self-administer. During an interview on [DATE] at 2:40 PM, Licensed Practical Nurse #7 was shown the photograph of the medication and stated that it should not have been left at the resident ' s bedside. Licensed Practical Nurse #7 stated that the medication should have been locked up in the medication cabinet. Licensed Practical Nurse #7 stated that since it had expired, it should have been discarded. Licensed Practical Nurse #7 stated that the Resident #44 had a new prescription filled for the ointment medication recently. Licensed Practical Nurse #7 stated that they had seen multiple instances where medications were left at the bedside from the overnight shift, and Licensed Practical Nurse #7 would collect the medications and place them back in the medication cart. Resident #358 Resident #358 was admitted to the facility with the diagnoses of dementia, chronic kidney disease (kidney dysfunction that does not improve), and Crohn ' s disease (an inflammatory bowel disease causing bloody stool and diarrhea). The Minimum Data Set, dated [DATE], documented the resident was understood and could usually understand others, with severe cognitive impairment. The Minimum Data Set also documented Resident #358 had wandered, wandered at significant risk to themselves, and that the wandering significantly intruded on the privacy and activities of others. The admission assessment dated [DATE] documented the resident was at high risk for elopement and that the high-risk elopement care plan and wander bracelet needed to be initiated. The Comprehensive Care Plan for cognitive loss/dementia, wandering related to the diagnosis of dementia, created [DATE], last updated on [DATE], documented the long-term goal was Resident #358 would wander safely within specified boundaries and remain free from injury/harm. The approaches dated [DATE], included equip resident with a device that alarms when resident wanders and check for proper functioning per facility protocol. The approaches dated [DATE], documented 30-minute supervisory checks, and diversional activities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The approaches dated [DATE], documented have door slightly open at night, keep bathroom light on, and place sign outside of resident ' s door to help identify their room. The evaluation notes dated [DATE], documented Resident #358 utilized a wander guard on their left ankle and right wrist for their safety. The resident continued to desire to find their spouse and was ambulatory throughout the unit. The Comprehensive Care Plan for behavioral symptoms, risk for elopement related to cognitive impairment with independent ambulation, and known wandering tendencies, created [DATE], last updated [DATE], documented the long-term goals of Resident #358 were that they would not wander out of the facility or off the unit without supervision at any time, Resident #358 would remain safely engaged in activity focused care and have meaningful interventions without making attempts to elope from facility. The approaches dated [DATE], documented determine peak hours of wandering and provide increased supervision during those periods, check wander guard placement minimally every shift, and check functionality of bracelet daily. The approaches dated [DATE] documented 15-minute visual checks to ensure resident was in a safe location and additional wander guard was applied to resident ' s right wrist due to elopement on [DATE]. A physician ' s order dated [DATE], documented the placement of a wander guard on the resident ' s left ankle. The wander guard number documented was 996 and had an expiration date of 08/2025. A physician ' s order dated [DATE], documented the placement of a wander guard on the resident ' s left ankle. The wander guard number documented was 1262 and had an expiration date of 04/2026. A physician ' s order dated [DATE], documented the placement of a wander guard on the resident ' s right wrist. The wander guard number documented was 996 and had an expiration date of 08/2025. A physician ' s order dated [DATE], documented to visualize wander guard on resident then utilize secure care tester to ensure wander guard functioning. Left ankle and right wrist once a day. On [DATE] at 5:45 PM, Resident #358 eloped from Unit 1 to the main lobby of Memorial Campus, a building adjoined by hallways to the nursing home facility. Facility report documentation from the incident documented Resident #358 was looking for their family, had wandered off the unit without triggering the alarm system, was found by a security guard in the main lobby of the adjoined building, and after they were identified as a facility resident, they were returned to the unit by staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:54 AM, Unit Coordinator #1 stated they were not there when the elopement happened but heard about it. Unit Coordinator #1 stated that new doors were installed on the 1st floor after the incident. Additionally, they had a wand on the floor that they used to check the wander guards ' functionality every day. Maintenance checked them too. Registered Nurse #1 joined the conversation and stated that elopement risk assessments were completed by a Registered Nurse upon admission, aides did 15-minute safety checks on high-risk residents, Licensed Practical Nurses helped keep an eye on residents that wandered, and there was a lead Registered Nurse usually posted near the door. If a resident had a wander guard, everyone on the unit was made aware of it and there was a book with each resident's information and picture so that everyone could identify the residents. Registered Nurse #1 stated that a house-wide education was done after the event. During an interview on [DATE] at 3:24 PM, Engineering Supervisor #1 stated that maintenance staff checked the exit door operation of the elopement prevention system utilizing an activated bracelet and verified that the exit door elopement prevention engaged and alarmed. During an interview on [DATE] at 3:247PM, Director of Nursing #1 stated that the night shift (e.g., third shift) staff checked the bracelet function of the elopement prevention system utilizing a hand-held device to verify that the bracelet was activated. During an interview on [DATE] at 9:18 AM, Director of Nursing #1 stated that staff had seen Resident #358 roughly 15 minutes before they got off the unit. Director of Nursing #1 stated that it happened and it had not happened since. Once the incident occurred, the facility adjusted the alarm system, educated the staff, and double alarmed Resident #358. Director of Nursing #1 stated it was a tough case because the resident was completely independent and was always trying to get to their family. 10 New York Codes, Rules and Regulations 483.25(d)(1)(2)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated (Case # NY00358788) survey, the facility did not ensure it had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Specifically, (a.) the facility did not perform the appropriate competency evaluations for licensed nursing staff to measure the pattern of knowledge, skills, abilities, behaviors and other characteristics that an individual needs to perform work roles or occupational functions successfully; (b) Registered Nurse Supervisor #1 did not document or assess Resident #359 when a procedure was ordered, and mental status changes occurred. Registered Nurse Supervisor #1 did not remain available to assess the resident during an ordered procedure that required assessment, evaluation, and follow up intervention to the medical record and the resident ' s Comprehensive Care Plan. No documentation or report was given to the oncoming Registered Nurse prior to Registered Nurse Supervisor #1 leaving the facility at the end of their shift. This is evidenced by: Cross reference to F684. A facility assessment dated 2024, documented under Part 14 - Staff Training /Education, that training programs applied to all facility staff to include direct care staff, indirect care staff, managers, supervisors, contracted staff, and volunteers, as appropriate. Training programs, as appropriate, were provided as part of their orientation process for new and newly assigned staff, annually, and/or as needed. Training programs contained learning objectives, performance standards, and evaluation criteria. A review of education records for Licensed Practical Nurse #2 documented that their educations for the following topics expired in [DATE]: Fire Safety, Ethical Behaviors, Emergency Management Plan, Emergency Codes, Electrical Safety, Developing Cultural Competencies in Healthcare, Core Compliance: Fraud, and Abuse, Health Insurance Portability and Accountability Act and Emergency Medical Treatment and Active Labor Act Basics, Active Shooter, and 2022 Health Insurance Portability and Accountability Act. A review of education records for Certified Nurse Aide #5 documented that their educations for the following topics expired in [DATE]: Fire Safety, Evacuation Plan, Hazard Communication, Emergency Management Plan, Developing Cultural Competencies in Healthcare, Emergency Codes, Electrical Safety, Human Immunodeficiency Virus & Acquired Immunodeficiency Syndrome Confidentiality, Infant and Child Abduction, Patient & Resident Abuse, Patient Rights, Policy on the Rights of Employees to Express Breast Milk in the Workplace, Personal Protective Equipment Refresher, Professional Wellness & Impairment, Sexual Harassment Prevention, Core Compliance: Fraud & Abuse, Health Insurance Portability and Accountability Act and Emergency Medical Treatment and Active Labor Act Basics, Suicide Awareness and Response, and Active Shooter. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:05 AM, Assistant Director of Nursing #1 stated that they were responsible for the education records of the nursing staff. Assistant Director of Nursing #1 stated that they did not review the education records as much as they should. They had lost track of the education records of in-house staff due to other responsibilities, and it had been months since they had reviewed any of them. They stated that they would make sure that the person that took on their position as Assistant Director of Nursing would be more diligent about reviewing the records. During an interview on [DATE] at 9:18 AM, Director of Nursing #1 stated that they were unaware of the lapse in staffing education records. Director of Nursing #1 stated that they would follow up with Assistant Director of Nursing #1. Resident #359 Resident #359 was admitted to the facility with diagnoses of status post spinal surgery for a pathological compression fracture (a broken bone caused by underlying disease), diabetes mellitus (a disorder where the body does not produce enough insulin and the person has consistently high blood sugar), and morbid obesity (too much body fat which increases the risk of health problems). The Minimum Data Set (an assessment tool) dated [DATE] documented the resident could understand and was understood by others with intact cognition for daily decision making. During a telephone interview on [DATE] at 1:35 PM, Registered Nurse Supervisor #1 stated they were notified Resident #359 had returned from the hospital on [DATE], had a period of apnea, and was unresponsive. After responding to the unit, 911 was called and the physician was notified. When Emergency Medical Services arrived, Resident #359 was assessed, had become responsive, and refused to go back to the hospital. The physician was notified of the resident ' s refusal, and an order was obtained to bladder scan the resident and catheterize them if urine residual was greater than 400 milliliters. Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #2 was assigned to the resident and was going to perform the catheterization. Registered Nurse Supervisor #1 stated that the resident was stable when they left the unit, and Registered Nurse Supervisor #1 stated they were not aware of anything that had happened until the following day when they returned to the facility. Registered Nurse Supervisor #1 stated that Licensed Practical Nurses could not assess a resident with a change in condition and they needed to notify a Registered Nurse to complete an assessment. Registered Nurse Supervisor #1 stated they were the only Registered Nurse in the building on evenings and had not checked back on the resident ' s condition prior to leaving for the night. No documentation had been placed on the 24-hour report about the resident ' s episode, refusal to go to the hospital, or the events surrounding Resident #359 ' s change in condition and subsequent catheterization. Registered Nurse Supervisor #1 further stated they did not give a shift report to the oncoming nurse and stated that they couldn ' t remember if there was an oncoming nurse at the time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335857	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilkinson Residential Health Care Facility	4988 State Hwy 30 Amsterdam, NY 12010

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 12:45 PM, Medical Director #1 stated that they were notified on [DATE] that Resident #359 had an episode of unresponsiveness. The physician told the staff to send Resident #359 to the hospital and staff contacted Emergency Medical Services. Medical Director #1 stated that after they were notified, staff called again, and stated the resident had become alert and had refused to go to the hospital. Because Resident #359 had just returned to the facility that day ([DATE]) and there was concern that the hospital had removed their foley prior to their return to the facility, the physician ordered a bladder scan to be done. Medical Director #1 stated that if the results of the bladder scan was greater than 400 millimeters of residual urine, the order was for staff to insert a foley catheter. Medical Director #1 stated that staff did not call to inform them of (a.) the results of the bladder scan - Results of the bladder scan being that Resident #359 had greater than 850 milliliters of urine retention and needed to be catheterized - (b.) the subsequent insertion of the foley catheter, or (c.) the difficulty the staff and resident experienced to carry out the order. Medical Director #1 stated that they did not receive notification of the resident ' s condition until [DATE], 72 hours later when they were informed of Resident #359 ' s condition by Director of Nursing #1. Medical Director #1 stated that the staff should have called and advised them of what had occurred. Medical Director #1 further stated that the Registered Nurse should have reassessed the resident at the time and discussed the situation with them - the physician, so they could have collaboratively decided what would have been the best way to proceed with Resident #359. During an interview on [DATE] at 3:00 PM, Director of Nursing #1 stated they were not made aware of the issues surrounding the events with Resident #359 on [DATE] until the morning of [DATE]. Director of Nursing #1 stated that Registered Nurse Supervisor #1 had not reported any issues with Resident #359, despite there being many issues at that time, and should have checked with the Licensed Practical Nurses prior to leaving for the night given that Resident #359 had an episode of unresponsiveness and mental status changes. Director of Nursing #1 stated that only a Registered Nurse could assess a resident with a change in condition and because only Licensed Practical Nurses were present at the time of the issues with Resident #359, Registered Nurse Supervisor #1 should have followed up or provided report to the oncoming Registered Nurse. Director of Nursing #1 stated that staff should have been in contact with the Registered Nurse and Physician throughout the whole incident. Director of Nursing #1 stated all staff were reeducated on the policy of notifying the physician when a resident experienced a change in condition. Director of Nursing #1 stated that the situation was not handled per policy, Registered Nurse Supervisor #1 and the other staff did not follow professional standards of care. 10 New York Codes, Rules and Regulations 415.26(c)(1)(iv)