STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335878	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Rehabilitation and Nursing at White Plains	120 Church Street White Plains, NY 10601

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. 40686 Based on observation, interview, and record review conducted during the recertification survey from 10/3/2024 to 10/11/2024, the facility did not ensure residents were treated with respect and dignity. Specifically, several nursing staff on the Dementia unit were observed without identification badges. The findings are: The facility policy titled Identification Badge dated 1/20/2020 documented all staff were required to wear an identification badge while in the facility. The facility policy titled Quality of Life - Dignity dated 7/2019 documented staff shall keep the resident informed and oriented to their environment. On 10/03/2024 at 12:10 PM, Certified Nursing Assistant #13 was observed walking from the 5th Floor Nursing Station across the resident lounge area and towards the Dayroom. Certified Nursing Assistant #13 was observed without an identification badge and when approached, stated they forgot their badge in their bag. Certified Nursing Assistant #13 turned around towards the Nursing Station and returned wearing an identification badge. Certified Nursing Assistant #15 was observed walking across the resident lounge and towards the Dayroom. After being approached and asked whether they had identification, Certified Nursing Assistant #15 stated they worked for facility and had an identification badge in their bag. Certified Nursing Assistant #15 then asked, Do you want me to go get it? On 10/4/2024 at 2:45 PM, Resident #37's Designated Representative was interviewed and stated staff on the 5th Floor did not consistently wear identification badges which was confusing for the residents because of their cognitive impairments and concerning to the visitors and families in terms of staff accountability and dignity and respect for the residents. On 10/11/2024 at 10:21 AM, Certified Nursing Assistant #16 was observed talking with Certified Nursing Assistant #19 in the 5th Floor Dayroom while 15 residents sat in their wheelchairs either falling asleep or watching television. Neither of the Certified Nursing Assistants interacted with or acknowledged the residents in the Dayroom. Certified Nursing Assistant #16 was approached and observed without an identification badge. Certified Nursing Assistant #16 identified themselves by first name only and stated they were a new employee and was on orientation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2024 at 12:59 PM, the Human Resources Director was interviewed and stated they were on leave from 12/2023 through 3/2024 and the identification badge machine was not functional. An email was sent to all employees to inform them of the various ways they can secure an identification badge and directing them to do so if they did not currently have an identification badge. All new employees were provided with identification badges prior to them working on resident units. On 10/11/2024 at 1:30 PM, the Director of Nursing was interviewed and stated they performed regular rounds of the resident units to observe staff performance. The Director of Nursing stated staff compliance with wearing identification badges was identified as a persistent concern. They stated staff education had not been consistent. On 10/11/2024 at 2:16 PM, the Administrator was interviewed and stated they made regular rounds of the resident units and tried to make sure staff were in compliance with wearing identification badges. 10 NYCRR 415.5(a)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. 50766 Based on observation, record review, and interviews during the recertification survey conducted from 10/3/24 - 10/10/24, the facility did not ensure residents were informed during their stay of their rights and rules and regulations governing resident conduct and responsibilities. Specifically, the facility did not ensure resident rights were provided or reviewed during monthly Resident Council meetings. Findings include: An undated Policy and Procedure titled Resident Council did not include documentation that a review of residents' rights was conducted at Resident Council meetings. A record review of Resident Council Meeting Minutes dated April 2024 to August 2024 did not include documentation that residents' rights were reviewed. A Resident Council meeting was conducted on 10/4/2024 at 11:00 AM. Eleven members attended, including the President and [NAME] President of Resident Council. Residents stated resident rights were not discussed during resident council meetings. Residents stated they were provided information regarding resident rights upon admission but no further review or notification of updates or changes regarding resident rights concerns had been addressed. During an interview on 10/7/2024 at 1:15 PM the Director of Social Services/Grievance Official stated they were aware of Resident Council meetings and did review minutes of meetings after each meeting with the Director of Activities. They stated resident rights information was provided in admission packets and posted in day rooms on each floor of the facility. They stated that after admission to the facility, resident rights information was available to residents upon request only and they did not provide an annual paper copy to residents. The Director of Social Services also stated resident rights could be discussed with residents in person, at resident council meetings or during care plans meetings, but there was no routine or annual discussion. They stated they were not able to provide documentation that resident rights were reviewed annually with the residents, or that they had been reviewed at the last five Resident Council meetings and/or during care plan meetings. 10 NYCRR 415.3

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/03/24 to 10/11/24, the facility did not ensure the development and implementation of comprehensive person-centered care plans to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident (Resident #96) reviewed for self-administration of medications. Specifically, the facility did not develop a care plan to address Resident #96 carrying and self-administering their albuterol sulfate aerosol inhaler. The findings are: The facility policy titled Care Plans, Comprehensive Person-Centered dated 7/2019 documented the Interdisciplinary Team in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person centered care plan for each resident. The comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident #96 was admitted with chronic obstructive pulmonary disease, chronic atrial fibrillation, chronic rhinitis, and shortness of breath. The 9/7/24 Quarterly Minimum Data Set documented Resident #96 had intact cognition and received 7 days of respiratory therapy. The 9/19/24 physicians' orders documented Resident #96 was to receive albuterol sulfate HFA 90 mcg/actuation aerosol inhaler by inhalation route every 4 hours as needed with instructions to leave the inhaler in the room and can self-administer. On 10/03/24 at 10:49 AM, Resident #96 was observed in their room with an albuterol sulfate inhaler and stated they could use the inhaler whenever they wanted, because it was their escape inhaler for the feelings of chest tightness. They stated the inhaler was always at their bedside. There was no documented evidence in the electronic medical record that a Self-Administration of Medication Care Plan was initiated prior to 10/6/24. On 10/10/24 at 03:40 PM, the Director of Nursing stated the registered nurses were responsible for initiating Care Plans and all residents should have care plans to reflect their plan of care. They stated if a resident was assessed to self-administer medications, the care plan should have been initiated immediately after the assessment and approval to self-administer medications. 10 NYCRR 415.11(c)(1)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (NY00329183) from 10/3/2024 to 10/11/2024, the facility did not ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain their highest practicable wellbeing in accordance with the facility assessment. This was evident on 2 (5th Floor and 4th Floor) of 4 resident units. Specifically, 6 of 6 Certified Nursing Assistant personnel files contained no evidence of practical competency in basic nursing skills and activities of daily living, and 4 of 4 licensed nursing personnel files did not contain competency assessments of medication management. The findings are: The Facility assessment dated [DATE] documented every staff member had knowledge competency in abuse, resident rights, identification of condition change. Additional training for all staff included dementia/behavioral management. Nursing has additional training for basic nursing skills, activities of daily living, skin and wound care, and medication management. Competencies were based on current standards of practice, may include return demonstration, observed behavior, and observed ability. Competencies were verified upon orientation, at least annually, and as needed. Please refer to F760 and F761. Upon review of Licensed Practical Nurse #2, Registered Nurse #3, Licensed Practical Nurse #4, and Registered Nurse #6 personnel records, there was no documented evidence medication management and other basic nursing services competencies were performed. Upon review of Certified Nursing Assistant #12, #13, #14, #15, #16, and #17 personnel records, there was no documented evidence competencies related to activities of daily living and basic nursing skills were performed. A sample of the facility Orientation/Annual Inservice information packet provided to new hires and during annual reeducation documented the list of topics staff were to be knowledgeable and proficient. There was no documented evidence medication management, basic nursing skills, activities of daily living, dementia care, or behavioral health and management were part of the orientation or annual inservice package. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 at 12:40 PM, the Human Resources Director was interviewed and stated the communication between Human Resources and the Nursing department related to disciplinary actions and rule violations has not been ideal. The Human Resources Director became aware of concerns with employee job performance and incidents when the Nursing Department wanted an employee suspended, however, there were other levels of progressive disciplinary action that needed to occur before an employee received a suspension. There were meetings with corporate personnel and the new Director of Nursing was better at communicating with Human Resources. The Human Resources Director stated they were responsible for ensuring new hires provided certain information and were provided with the employee handbook and corporate compliance information. The staff Inservice Educator was removed from that position in 6/2024 and placed back into the position of charge nurse. No one replaced the Inservice Educator for the facility. The Director of Nursing and Human Resources Director attempted to provide staff with their required annual inservice and trainings, but staff reported, if they were not getting paid to complete their inservices, they were not going to complete them. The facility did utilize online web-based trainings; however, the facility was not equipped with computer terminals and/or space for employees to complete inservices while on site at the facility. Behavior management and dementia care were not included in the annual inservices, trainings, and competencies. After 90 days of a new hire working for the facility, a performance evaluation was supposed to be performed by the director of the department. On 10/11/2024 at 1:06 PM, the Assistant Director of Nursing was interviewed and stated they were responsible for the competency evaluations and inservices/trainings for all the units and nursing staff. Certified Nursing Assistant competencies included observing the provision of care, transfers, feeding, and mechanical lift use. Licensed Nurses were observed and evaluated for medication administration, storage of medications, and whether they used the medication carts appropriately. The Assistant Director of Nursing stated they only recall conducting competencies and performance evaluations related to episodic incidents, complaints, and/or concerns. Annual performance evaluations were conducted by the Director of Nursing and the Assistant Director of Nursing stated they were not involved in that process. The Assistant Director of Nursing stated they recall completing approximately 5-10 performance evaluations of new hires within the past 6 months. On 10/10/2024 at 3:42 PM and 10/11/2024 at 01:30 PM, the Director of Nursing was interviewed and stated the system in place to ensure competency evaluations of nursing staff was not the best. Competency evaluations of nursing staff skills and abilities were not consistently being done. Education and inservice was also not consistent with nursing staff. Behavior management and dementia care inservices were initiated for all nursing staff upon incident as of 10/4/2024. The Nursing Administration attempted to ensure competency evaluations were done upon orientation and annually. Nurse managers were responsible for inservicing and educating nursing staff on the units. The Director of Nursing stated inservices, trainings, and competencies were now part of their responsibility since they took on the role in 6/2024. The facility no longer had a Inservice Educator position, and the position was absorbed into the Director of Nursing's responsibilities. On 10/11/2024 at 2:16 PM, the Administrator was interviewed and stated they were unsure whether competencies and performance evaluations were being performed for nursing staff. Competencies and performance evaluations were supposed to be done annually for all employees. The Administrator stated they were responsible for ensuring a system was in place to evaluate the competency and performance of all staff including nursing staff. 10 NYCRR 415.26(c)(1)(iv)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00329183) from 10/3/2024 to 10/11/2024, the facility did not ensure a performance review of every nurse aide at least once every 12 months, and regular in-service education based on the outcome of these reviews. This was evident on 1 (5th Floor) of 4 resident units. Specifically, 6 of 6 Certified Nursing Assistant personnel files contained no evidence of performance evaluations and inservice based on the results of performance evaluations. The findings are: The Facility assessment dated [DATE] documented every staff member had knowledge competency in abuse, resident rights, identification of condition change. Additional training for all staff included dementia/behavioral management. Nursing has additional training for basic nursing skills, activities of daily living, skin and wound care, and medication management. Competencies were based on current standards of practice, may include return demonstration, observed behavior, and observed ability. Competencies were verified upon orientation, at least annually, and as needed. The Facility Survey Report dated 10/3/2024 documented each nurse aide was required to receive 6 hours of paid inservice training every 6 months. The list of survey topics since last survey (3/8/2022) documented 9. 75 total hours of inservice provided to nurses' aides. Behavioral health care and/or management were not included in the list of inservice topics provided to staff. Upon review of Certified Nursing Assistant #12, #13, #14, #15, #16, and #17 personnel records, there was no documented evidence of annual performance evaluations or of 12-hour annual inservice required to ensure competent skills and abilities. A sample of the facility Orientation/Annual Inservice information packet provided to new hires and during annual reeducation documented the list of topics staff were to be knowledgeable and proficient. There was no documented evidence medication management, basic nursing skills, activities of daily living, dementia care, or behavioral health and management were part of the orientation or annual inservice package. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 at 12:40 PM, the Human Resources Director was interviewed and stated the communication between Human Resources and the Nursing Department related to disciplinary actions and rule violations had not been ideal. The Human Resources Director became aware of concerns with employee job performance and incidents when the Nursing Department wanted an employee suspended, however, there were other levels of progressive disciplinary action that needed to occur before an employee received a suspension. There were meetings with corporate personnel and the new Director of Nursing was better at communicating with Human Resources. The Human Resources Director stated they were responsible for ensuring new hires provided certain information and were provided with the employee handbook and corporate compliance information. The staff Inservice Educator was removed from that position in 6/2024 and placed back into the position of charge nurse. No one replaced the Inservice Educator for the facility. The Director of Nursing and Human Resources Director attempted to provide staff with their required annual inservice and trainings, but staff reported, if they were not getting paid to complete their inservices, they were not going to complete them. The facility did utilize online web-based trainings; however, the facility was not equipped with computer terminals and/or space for employees to complete inservices while on site at the facility. Behavior management and dementia care were not included in the annual inservices, trainings, and competencies. After 90 days of a new hire working for the facility, a performance evaluation was supposed to be performed by the director of the department. On 10/11/2024 at 1:06 PM, the Assistant Director of Nursing was interviewed and stated they were responsible for the competency evaluations and inservices/trainings for all the units and nursing staff. Certified Nursing Assistant competencies included observing the provision of care, transfers, feeding, and mechanical lift use. Licensed Nurses were observed and evaluated for medication administration, storage of medications, and whether they used the medication carts appropriately. The Assistant Director of Nursing stated they only recalled conducting competencies and performance evaluations related to episodic incidents, complaints, and/or concerns. Annual performance evaluations were conducted by the Director of Nursing and the Assistant Director of Nursing stated they were not involved in that process. The Assistant Director of Nursing stated hey recall completing approximately 5-10 performance evaluations of new hires within the past 6 months. On 10/10/2024 at 3:42 PM and 10/11/2024 at 1:30 PM, the Director of Nursing was interviewed and stated the system in place to ensure competency evaluations of nursing staff was not the best. Competency evaluations of nursing staff skills and abilities were not consistently being done. Education and inservice was also not consistent with nursing staff. Behavior management and dementia care inservices were initiated for all nursing staff upon incident as of 10/4/2024. The Nursing Administration attempted to ensure competency evaluations were done upon orientation and annually. Nurse managers were responsible for inservicing and educating nursing staff on the units. The Director of Nursing stated inservices, trainings, and competencies were now part of their responsibility since they took on the role in 6/2024. The facility no longer had a Inservice Educator position, and the position was absorbed into the Director of Nursing's responsibilities. On 10/11/2024 at 2:16 PM, the Administrator was interviewed and stated they were unsure whether competencies and performance evaluations were being performed for nursing staff. Competencies and performance evaluations were supposed to be done annually for all employees. The Administrator stated they were responsible for ensuring a system was in place to evaluate the competency and performance of all staff including nursing staff. 10 NYCRR 415.26(c)(2)(iii)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 10/3/2024 to 10/11/2024, the facility did not ensure a resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This was evident for 1 (Resident #107) of 33 sampled residents. Specifically, Resident #107 exhibited behavior without any non-pharmacological intervention or staff interaction to address their behaviors. The findings are: The facility policy titled Behavioral Assessment, Intervention, and Monitoring dated 7/2019 documented the facility will provide behavioral health services provided by qualified staff who have the competencies and skills necessary to provide appropriate services to the residents. The Facility Survey Report dated 10/3/2024 documented each nurse aide was required to receive 6 hours of paid inservice training every 6 months. The list of survey topics since last survey (3/8/2022) documented 9. 75 total hours of inservice provided to nurses' aides. Behavioral health care and/or management were not included in the list of inservice topics provided to staff. Resident #107 had diagnoses of cerebral infarction, anxiety disorder, and unspecified dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #107 was severely cognitively impaired, declined to respond to mood questions, did not display any behaviors, and received antianxiety and antidepressant medication. The Comprehensive Care Plan related to Cognition initiated 5/29/2023 and last updated 4/10/2024, documented Resident #107 was alert with short term memory loss and moderate judgment impairments. Interventions included anticipate resident needs, monitor for changes, remind resident of daily routine, support, and praise resident choices. The Comprehensive Care Plan related to Mood initiated 5/26/2023 and last updated 4/10/2024 documented Resident #107 had altered mood state or feelings, as manifested by resident showing signs of sadness, reduced social interaction, and unpleasant mood in the morning. The Comprehensive Care Plan related to Potential Victim/Victimizer initiated 5/26/2023 and last reviewed 6/25/2024 documented Resident #107 swung their hands in another resident's face on 6/25/2024. Interventions included redirection, do not sit Resident #107 near their aggressor, remove Resident #107 from a confrontational situation, and psychology services as appropriate. The Comprehensive Care Plan related to Activities initiated 6/3/2023 and last reviewed 3/30/2024 documented Resident #107 would be provided with an activity calendar, would be provided with transportation to and from activities, would have emphasis on social interaction and reminiscing, and would be monitored for any new activity interests. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan related to Behavior initiated 7/8/2024 documented Resident #107 screamed, yelled, called out expletives, flailed arms, leaned their head on the table, and threw items within their reach. The care plan was updated 9/11/2024 and included interventions to offer Resident #107 a pillow, intervene as needed to ensure the safety of resident and others, speak to resident in calm manner, attempt to distract Resident #107 and anticipate problem triggers. The care plan was last revised 9/27/2024 and documented Resident #107 smacked a nurse on the shoulder and attempted to pinch them during a dressing change. There was no documented evidence Resident #107's care plans related to cognition, activities, and mood were reviewed and revised to include non-pharmacological interventions to address Resident #107's behaviors. Physician orders dated 7/10/2024 documented Resident #107 had a diagnosis of anxiety disorder and required 2 staff to provide care, weekly behavior notes, document resident behavior every shift. Nursing Notes from 7/2/2024 to 7/9/2024 documented Resident #107 displayed behaviors of cursing, threatening, flailing arms, and attempting to grab objects within their reach. Staff response was to monitor and document. The Physician Note dated 7/11/2024 documented increase citalopram to 20 mg daily due to Resident #107's behaviors of calling out and being disruptive. Nursing Note dated 7/24/2024 documented Resident #107 refused medications, hits, kicks, and plays with feces. Psychiatry Consult dated 8/24/2024 documented Resident #107 made inappropriate comments and to continue non-pharmacological interventions to manage behaviors. Nursing Notes dated 9/2/2024, 9/10/2024, and 9/21/2024 documented Resident #107 had behavior of loudly banging on the table, putting their head down on the table, and self-inflicting scratches on their chest. There was no documented evidence non-pharmacological interventions were used to address Resident #107's behaviors. Recreation Note dated 9/26/2024 documented Resident #107 was receptive to 1 to 1 visits, music, and peer socialization. The Resident Instruction Sheet dated 10/11/2024 documented the Certified Nursing Assistants were required to notify the nurse of Resident #107's behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/2024 at 11:55 AM, Resident #107 was observed in their wheelchair in the corner of the 5th Floor Dayroom alone, with head in hands, hair stringy greasy and unbrushed, and shirt stained. No residents were seated near, and staff did not acknowledge or interact with Resident #107. At 12:35 PM, Resident #107 was observed in the same position and location of the dayroom. An overbed table was positioned out of reach, approximately 3 feet in front of Resident #107, with a lunch meal tray on it. Staff did not assist Resident #107 with setting up their meal tray and Resident #107 did not acknowledge or attempt to get their meal tray as other residents in the dayroom were fed and/or eating from their trays. On 10/03/2024 from 3:26 PM to 3:55 PM, Resident #107 was heard from the elevator entering the unit approximately 50 feet from the 5th Floor Dayroom screaming, howling, and repeating I can't breathe, I am hungry, please get me some food. The 5th Floor Dayroom had 14 residents seated in wheelchairs. No activity or interaction was observed by staff present. Resident #107 was seated against the back wall in their wheelchair and continually screamed and howled loudly. Staff did not attempt to intervene, interact with Resident #107, or provide any other non-pharmacological intervention. Resident #107 was interviewed at the time of the observation and stated they were hungry and thirsty. Resident #107 requested juice. A Certified Nursing Assistant was present and did not respond or react to Resident #107's requests. On 10/04/2024 at 11:14 AM, Resident #107 was observed in the 5th Floor Dayroom in their wheelchair with their head down and laying on top of their arms that were folded and leaning on the table in front of them. Resident #107 was responsive to verbal stimuli and stated, I am lonely. There were 14 residents in the dayroom and the Recreation Leader was observed interacting with 2 of residents by providing them coloring materials. The Activity Calendar on the wall had Word Play and Short Stories on Unit 5 at 11 AM. There were no observed ongoing activities in the Unit 5 dayroom. The Recreation Leader was interviewed at the time of the observation and stated they provided reminders during activities to ensure the residents remembered what activities they were currently participating in. One of the residents asked to color. The other residents were asked if they wanted to color. If the residents did not want to color, they sat there in the dayroom. On 10/04/2024 at 3:02 PM, Resident #107 was observed in their wheelchair alone in the corner of the 5th Floor Dayroom. Resident #107 was tearful, screamed, and stated they were confused. The staff present in the dayroom did not respond or interact with Resident #107. On 10/11/2024 at 10:37 AM, Certified Nursing Assistant #14 was interviewed and stated they were previously assigned to Resident #107 and knew the resident loved their son and former President Obama. Resident #107 could be combative during care and in the dayroom. Resident #107 was known to have verbal outbursts. On 10/11/2024 at 10:29 AM, Certified Nursing Assistant #19 was interviewed and stated they were hired months ago and was assigned to the 5th Floor Dayroom to watch the residents. Certified Nursing Assistant #19 stated their assignment changed daily and they reviewed their assignment in the morning when they arrived at work. The nursing staff informed Certified Nursing Assistant #19 of residents on their assignment that exhibited behaviors and how to address those behaviors. Certified nursing Assistant #19 stated some resident behaviors were ignored. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Rehabilitation and Nursing at White Plains	120 Church Street White Plains, NY 10601

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2024 at 11:42 AM, the Director of Recreation was interviewed and stated they were hired approximately 8 months ago. The 5th Floor Dementia unit was scheduled to have Puppet Visits this morning. The Activity Calendar was not followed and scheduled activities did not occur because of timing conflicts with the kitchen. In the morning, the Recreation Leader was responsible for serving coffee to each of the residents in their rooms. The Recreation Leader was also responsible for handing out chronicles and reading them to residents during 1 to 1 interaction in their rooms. The kitchen was late with providing the coffee and the Recreation Leader was always delayed which led to activities either being pushed back or canceled. The Director of Recreation stated their response to the scheduling conflicts was to slowly remove coffee time from the calendar altogether even though residents on the Dementia Unit enjoyed that morning 1 to 1 activity and interaction. The Director of Recreation stated they attempted to resolve the timing issues with the kitchen without good effect. The Director of Recreation stated they did not inform the Administrator or make the Activity Calendar scheduling issues part of a Quality Assurance Performance Improvement Project. On 10/11/2024 at 12:40 PM, the Human Resources Director was interviewed and stated behavioral health and management and dementia care were not part of the facility's annual inservice requirements for staff. On 10/11/2024 at 1:30 PM, the Director of Nursing was interviewed and stated they believed the facility recently hired a psychologist but was unsure when psychological services began for the residents. The Director of Nursing stated behavior management and health became an inservice topic for staff beginning last week following an episodic concern on 10/4/2024. On 10/11/2024 at 2:16 PM, the Administrator was interviewed and stated they were unable to report whether required annual inservices and trainings were completed for all staff. The Administrator listed several topics of required annual inservice and did not mention behavioral health or management. Behavior management has not been included as a quality assurance performance improvement project. The facility hired a psychologist to provide psychological services in person at the facility 3 months ago. 10 NYCRR 415.12(f)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 10/3/2024 to 10/11/2024, the facility did not ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being. This was evident for 1 (Resident #24) of 33 total sampled residents. Specifically, Resident #24 was observed sitting in the floor dayroom on multiple occasions without being engaged in meaningful activities. The findings are: The facility policy titled Dementia-Clinical Protocol dated 7/2019 documented recreational activities will be supervised and supported throughout the day as needed. Resident #24 was diagnosed with dementia and anxiety disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #24 was moderately cognitively impaired. The Comprehensive Care Plan related to Cognitive Patterns initiated 5/3/2024 and last updated 5/8/2024 documented Resident #24 was alert with short- and long-term memory loss, moderately impaired decision making, and dementia. Interventions included monitoring and reporting/recording changes to Resident #24's cognition and mental awareness, encouraging Resident #24 to maintain present cognitive status, offering simple choices, and reminding Resident #24 to maintain a daily schedule. There was no documented evidence Resident #24's care plan related to cognitive loss was reviewed and revised upon Minimum Data Set 3.0 assessment dated [DATE]. The Comprehensive Care Plan related to Dementia initiated 6/27/2024 documented Resident #24 had a diagnosis of dementia and prevention included mind-stimulating, physical, and social activities. The care plan was last reviewed on 7/10/2024 and documented interventions included allowing Resident #24 time for decision making, time to process and responds, assisting resident to express their needs, breaking tasks into simple steps, and encouraging socialization and engagement with caregivers and peers. The Comprehensive Care Plan related to Activities initiated 5/4/2024 documented Resident #24 had moderate participation in recreation programs and expressed interest in group activities. Interventions included inviting and encouraging Resident #24 to attend activities and reminding, inviting, and escorting Resident #24 to recreation areas. The Activity Calendar for October 2024 documented 10/3/2024 Fall Crafts at 10:30 AM, Balloon Volleyball at 1:30 PM, and Movie Matinee at 2 PM on Unit 5. On 10/4/2024, the Activity Calendar documented Short Stories and Word Play at 11 AM and Darts at 2:30 PM on Unit 5. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/2024 at 3:29 PM, Resident #24 was observed sitting in the back of the floor dayroom alone staring at the floor and glancing at the television. On 10/04/2024 at 11:14 AM, 14 residents were observed in the 5th Floor dayroom. The Recreation Leader was observed at 1 table watching 2 residents color pictures. The 12 other residents in the dayroom sat with either their head in their hands or on the table falling asleep. The Activity Calendar on the wall had Word Play and Short Stories on Unit 5 at 11 AM. There were no observed ongoing activities in the Unit 5 dayroom. The Recreation Leader was interviewed at the time of the observation and stated they provided reminders during activities to ensure the residents remember what activities they were currently participating in. One of the residents asked to color. The other residents were asked if they wanted to color. If the residents did not want to color, they sat there in the dayroom. On 10/09/2024 at 04:14 PM, Registered Nurse #18 was interviewed and stated they could not recall the last time they received inservice or education related to dementia care and behavior management. On 10/10/2024 at 8:12 AM, Resident #24's Designated Representative was interviewed and stated Resident #24 had memory loss, confusion, and a diagnosis of dementia prior to their admission to the facility. Resident #24 expressed anxiety, paranoia, and confusion related to concerns from their childhood and had frequent episodes of falling. On 10/10/2024 at 02:24 PM, the Medical Director was interviewed and stated Resident #24 had a diagnosis of dementia and was a resident on the 5th Floor Dementia Unit. The Medical Director stated physicians did not perform any clinical workups related to a resident's dementia diagnosis and attempted to keep residents with dementia comfortable. Many of the 5th Floor residents were unable to go downstairs to the main dining room and activities were available to those residents in the 5th Floor dayroom. The physicians and nurse practitioner focused on not giving residents with dementia too much medication. If Resident #24 became agitated, the Psychiatric Nurse Practitioner was available to evaluate them. The facility did not have a contract with a Psychology Group and only used Psychiatric Services to address their resident's mental health needs. The Resident Nursing Instructions as of 10/11/2024 documented Resident #24 was alert with confusion. The Activity Calendar for October 2024 documented for 10/11/2024 Puppet Visits at 10:30 AM, Reminiscing/Storytelling at 11 AM, and Canvas Painting at 2:30 PM on Unit 5. On 10/11/2024 at 10:21 AM, Resident #24 was observed in the floor dayroom at a table with 3 other residents. Staff present in the floor dayroom had no interaction with Resident #24 or any other residents in the room. Resident #24 was observed falling asleep with their head in their hands. There were no Puppet Visits or Story Telling/Reminiscing observed on the unit. On 10/11/2024 at 10:29 AM, Certified Nursing Assistant #19 was interviewed and stated they were hired within the last 4 months and were assigned to the 5th Floor dayroom to watch the residents and make sure they did not fall. Certified Nursing Assistant #19 was unaware of the unit's designation as a Dementia Unit and stated their priority was ensuring residents did not get up from their wheelchairs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/11/2024 at 11:00 AM, Certified Nursing Assistant #14 was interviewed and stated Resident #24 liked to tell stories and hallucinated often. Resident #24's storytelling would get dark or negative at times and Certified Nursing Assistant #14 attempted to redirect Resident #24's hallucinations and delusions. Resident #24 enjoyed coloring and was always up and active. Today it appeared as though Resident #24 was more lethargic. Resident #24 had episodes of anxiety. On 10/11/2024 at 11:42 AM, the Director of Recreation was interviewed and stated they were hired approximately 8 months ago. The 5th Floor Dementia unit was scheduled to have Puppet Visits this morning. The Activity Calendar was not followed and scheduled activities did not occur because of timing conflicts with the kitchen. In the morning, the Recreation Leader was responsible for serving coffee to each of the residents in their rooms. The kitchen was late with providing the coffee and the Recreation Leader was always delayed which led to activities either being pushed back or canceled. The Director of Recreation stated their response to the scheduling conflicts was to slowly remove coffee time from the calendar altogether even though residents on the Dementia Unit enjoyed that morning 1 to 1 activity and interaction. The Director of Recreation stated they attempted to resolve the timing issues with the kitchen without good effect. The Director of Recreation stated they did not inform the Administrator or make the Activity Calendar scheduling issues part of a Quality Assurance Performance Improvement Project. On 10/11/2024 at 12:40 PM, the Human Resources Director was interviewed and stated behavioral health and management and dementia care were not part of the facility's annual inservice requirements for staff. On 10/11/2024 at 02:16 PM, the Administrator was interviewed and stated the Director of Recreation was hired with the intention to address the Dementia Unit population with an appropriate activity calendar. Sensory, music, and games that stimulate resident cognition were added to the Activity Calendar. The Administrator stated they were unaware that activities were removed from the calendar or canceled because of scheduling conflicts and delays from the Kitchen. The Administrator stated Dementia Care was part of the facility's quality assurance performance improvement projects however was unable to state how the facility quantified their performance in relation to providing residents with dementia care. 10 NYCRR 415.12

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review, and interview conducted during the Recertification and Abbreviated Surveys (NY00329183) from 10/03/24 to 10/11/24, the facility did not ensure residents were free of significant medication errors for 2 (Resident #202 and #96) of 9 residents reviewed for Medication Administration. Specifically, 1) Resident #202 was administered Lasix (diuretic) 20 milligrams and Losartan (antihypertensive) 100 milligrams without a physician's order, which resulted in the need for blood pressure monitoring every 30 minutes and intravenous fluids. 2) Resident #96 was about to receive a 4 milligram dose of Tizanidine (muscle relaxant) instead of the physician ordered 2 milligram dose during a medication observation that was stopped by the surveyor. The findings are: The facility policy titled Administering Medications dated 7/2019 documented individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right method(route) of administration before giving the medication. 1) Resident #202 was admitted with diagnoses including but not limited to chronic lower extremity paralysis, colostomy in left upper quadrant, and multiple sclerosis. The 5-day Minimum Data Set assessment dated [DATE] documented Resident #202 had intact cognition and was not receiving a diuretic. There was no documented evidence in the physician's order for the administration of Lasix or Losartan. The 11/29/23 Medications Care Plan documented to minimize potential complications from prescribed medications and administer medications per physicians' orders. The 11/30/23 Investigative Summary documented on 11/30/23, at approximately 8:30 AM, Resident #202 was given the wrong medication. The medication given was Lasix 20 milligrams and Losartan 100 milligrams. Upon investigation and staff interview, it was determined that the nurse gave the resident their roommate's medication in error. The Nurse Practitioner was notified, assessed the resident, and their blood pressure was stable. Intravenous fluids were started at 75 cubic centimeters per hour for one liter for hypotension, and blood pressure monitoring was ordered to be done every 30 minutes for 24 hours. Upon completion of the investigation and staff interview, the nurse was educated on the policy and procedures of medication administration and disciplinary action was taken. The 11/30/23 at 3:01 PM Nursing Progress note by the Assistant Director of Nursing documented Resident #202 experienced an episode of hypotension, the Nurse Practitioner assessed the resident, and gave new orders to administer normal saline, at 75 cubic centimeters per hour, and to monitor the blood pressure every 30 minutes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/30/23 Physicians orders documented Resident #202 was to have their blood pressure monitored every 30 minutes, receive Sodium Chloride 0.9% injection solution infused at 75 cubic centimeters per hour by intravenous route every hour for 12 hours until 1 liter bag was complete, a Urinalysis and Culture done one time, and insert a urinary catheter for urinary retention. During an interview on 10/08/24 01:00 PM, Licensed Practical Nurse #2 stated that on the day of 11/30/23, they administered the wrong medication to Resident #202. They stated they got distracted and mixed it up with the roommate's medications, and did not remember what was happening at the time. Licensed Practical Nurse #2 stated they did not verify the resident prior to administering their medications and made an error., Licensed Practical Nurse #2 stated that they realized they gave Resident #202 the medication after it was too late. During an interview on 10/10/24 at 11:41 AM, the Medical Director stated Lasix would cause an increased urination, lower potassium, and blood pressure, and Losartan could also lower the blood pressure. The Medical Director stated that orders were given for Resident #202 to have their blood pressure monitored and to receive intravenous fluids due to Losartan having a short half-life which can cause hypotension, and because Lasix can cause dehydration from excessive fluid loss. 2) Resident #103 was admitted with diagnoses including hyperlipidemia, major depressive disorder, pain, and paraplegia. The 7/25/24 Quarterly Minimum Data Set documented Resident #103 had intact cognition. The 1/23/24 Medications Care Plan documented to administer medications per physician orders. The physician order dated 10/7/24 documented to administer Tizanidine 2 milligram tablet of at 9:00 AM and 1:00 PM; administer Tizanidine 4 mg tablet at 5:00 PM. On 10/11/24 at 9:35 AM, during a medication administration observation, Licensed Practical Nurse #2 took a 4 milligram tablet of Tizanidine out of a blister pack and placed it inside the medication cup along with the other medication. Licensed Practical Nurse #2 then proceeded to go in the room to administer Resident #103 their medications. Licensed Practical Nurse #2 was stopped before they were able to administer the Tizanidine 4 milligram tablet. Licensed Practical Nurse #2 stated they overlooked the physician order and were going to give the wrong dose of the medication. Licensed Practical Nurse #2 stated that they should have checked the physician orders prior to administering medications, and they made a mistake. During an interview on 10/11/24 at 1:06 PM, the Assistant Director of Nursing stated they performed medication administration competencies with Licensed Practical Nurse #2 and have had continued conversations with Licensed Practical Nurse #2 due to previous medication errors. 10 NYCRR 415.12(m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/03/24 to 10/11/24, the facility did not ensure that all drugs and biologicals were stored in accordance with the manufacturer's specifications and professional standard of practice for 2 (Residents #12 and #96) of 8 residents reviewed for Medication Administration; and Medication and Treatment carts were observed unlocked. Specifically, 1.) Resident #12 was found with physicians ordered ipratropium nasal spray and an albuterol sulfate inhaler in their room on their bedside table. 2.) Resident #96 was found with 2 Trelegy inhalers, a Flonase nasal spray, an ipratropium nasal spray, an albuterol sulfate inhaler, and a triamcinolone acetonide ointment, and 3) the 5th Floor Medication Cart and Treatment Carts were left unlocked and open in the hallway accessible to residents, visitors, and unlicensed staff. The findings are: The facility policy titled Storage of Medications dated 7/2019 documented that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Resident #12 was admitted with the following diagnoses including but not limited to chronic obstructive pulmonary disease, chronic rhinitis, chronic atrial fibrillation, and functional dyspepsia. The 8/10/24 Quarterly Minimum Data Set documented that Resident #12 had intact cognition, had chronic obstructive pulmonary disease, and received 7 days of respiratory therapy. The 5/20/24 Medications Care plan documented to manage and minimize potential complications from prescribed medications. Interventions included administering medications per physicians' orders. Upon review of Care Plans, there were no documented evidence that there was a care plan for Resident #12 to self-administer their medications. The 4/27/24 Physician order documented that Resident #12 was to receive Ipratropium bromide nasal spray and spray 2 sprays by intranasal route 2 times per day for chronic rhinitis. The 8/14/24 Physician order documented that Resident #12 was to receive Albuterol Sulfate aerosol inhaler-inhale 2 puffs by inhalation route two times per day as needed with instructions to rinse mouth with water and spit after each use. On 10/03/24 at 10:05 AM, Resident #12 was observed in their room and the physician ordered ipratropium nasal spray and an albuterol sulfate inhaler were on their bedside table. Resident #12 stated that they used the albuterol twice a day and took it when they needed it and when they got a heavy feeling in their chest. They stated no one monitored them while they used it. Resident #12 stated that after using the albuterol inhaler, they did not rinse their mouth and spit (as per physician's instructions) and stated that they did not need to do that. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) Resident #96 was admitted with chronic obstructive pulmonary disease, chronic atrial fibrillation, chronic rhinitis, and shortness of breath. The 9/7/24 Quarterly Minimum Data Set documented that Resident #96 had intact cognition. Had chronic obstructive pulmonary disease, coronary artery disease, and peripheral vascular disease, and received 7 days of respiratory therapy. The 9/19/24 Physician orders documented to administer: - fluticasone propionate nasal spray in each nostril 2 times per day for allergic rhinitis. - ipratropium bromide nasal spray in each nostril by intranasal route 2 times per day for chronic rhinitis - Trelegy Ellipta for inhalation route once daily at the same time each day for asthma with instructions to rinse mouth with water and spit after use. - albuterol sulfate HFA 90 mcg/actuation aerosol inhaler by inhalation route every 4 hours as needed with instructions to leave the inhaler the room and can self-administer. The only medication with instructions to self-administer was the Albuterol, however review of Resident #96's record revealed no assessment or care plan to self-administer any medications. On 10/03/24 at 10:49 AM, Resident #96 was observed in their room with 2 Trelegy inhalers, a Flonase nasal spray, an ipratropium nasal spray, an albuterol sulfate inhaler, and a triamcinolone acetonide ointment at their bedside. Resident #96 was interviewed during the observation and stated they took the Fluticasone when they felt like they needed it. Resident #96 stated they took Trelegy once a day at any time. They could use ipratropium twice a day if they wanted too and when they felt like it, and the other inhalers they could use when they wanted. Resident #96 stated that they used the inhalers whenever they wanted as they were escape inhalers and they were used when their chest felt tight. On 10/04/24 at 08:39 AM, Resident #96 was observed with a Trelegy Inhaler on the dresser. Resident #96 stated that staff in came in the middle of night and took their escape inhaler and was very upset. Resident #96 began to cough, was breathing heavy and appeared to be having a panic attack and stated they need their escape inhaler. Resident #96 stated they did not understand why it was taken out of their room. The 10/6/24 at 9:51 AM Nursing progress note documented Resident #96 wanted to keep albuterol inhaler at bedside to administer as ordered and refused to return it to the nurse. Resident #96 was able to demonstrate proper usage and education was provided, and as per physician, Resident #96 may self-administer medications. During an interview on 10/10/24 at 12:33 PM, Licensed Practical Nurse #1 stated when a resident can self-administer medications, there usually was a physician's order, and that medication should not be left at the bedside with a physician's order to self-administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 02:15 PM, the Medical Director stated residents should be evaluated by the team to self-administer medications. The Medical Director stated that nurses were responsible to make sure that residents were taking the medications by themselves, and that they would discuss with nurses if a resident could self-administer and would give a verbal order that residents could self-administer. Nurses were responsible for putting the order into the computer and stated that it was in the regulation for the facility to have physician's order for a resident to self-administer their medications. During an interview on 10/10/24 at 03:40 PM, the Director of Nursing stated medications should not be left at resident's bedside unless they had an order to self-administer their medications. They stated that any resident that that wanted to carry and self-administer their own medications must be evaluated by the interdisciplinary team and must have a physician order to self-administer medications. 40686 3) On 10/03/2024 at 12:00 PM, the 5th Floor Medication Cart in the south hallway (lower room numbers) was observed unattended with staff, residents, and visitors passing by. The Medication Cart was unlocked, and all drawers were able to be opened. Several vials of injectable medication and inhalers were observed in the top drawer of the Medication Cart. The 2nd drawer of the Medication Cart contained resident blister packs of medication and a locked narcotics box. On 10/03/2024 at 12:20 PM, Registered Nurse #6 was approached, interviewed, and stated they were usually the night nurse and worked a double to cove someone that called out. They were responsible for the 5th Floor Medication Cart and was finished administering medications to the lower half of the floor. The Medication Cart should never be left unlocked. Registered Nurse #6 was asked to observe the Medication Cart and stated the cart was unlocked and they must have forgotten to lock the cart after administering morning medications. Registered Nurse #6 stated the Medication and Treatment Carts on the floor contain prescribed medication and should not be left open to residents, visitors, or non-licensed nursing staff. On 10/03/2024 at 12:59 PM, the 5th Floor Treatment Cart in front of room [ROOM NUMBER] was observed unlocked with several drawers containing prescribed topical ointments and creams, scissors, bandages, and other treatment items. There were no staff observed near the unlocked cart and residents, staff, and visitors passed by the cart without any supervision. On 10/04/2024 at 10:59 AM, the 5th Floor Treatment Cart was observed stationed against the wall outside of the Dayroom. No staff were observed using or stationed at the Treatment Cart which was observed unlocked and opened in the hallway accessible to residents, public, and other staff. At 11:02 AM, Licensed Practical Nurse #20 was interviewed and stated all resident treatments were done for the morning shift. No one was using the Treatment Cart, and it should be kept locked. Licensed Practical Nurse #20 observed the unlocked Treatment Cart and stated they did not know why the Treatment Cart was left unlocked, but the Treatment Cart should always be kept locked. 10 NYCRR 415.18(e)(1-4)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Rehabilitation and Nursing at White Plains	120 Church Street White Plains, NY 10601

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/03/24 to 10/11/24, the facility did not ensure that it provided or obtained emergency dental services to meet the needs of each resident for 1 (Resident #56) of 2 residents reviewed for Dental Services. Specifically, Resident #56 was evaluated by the Dentist for a fractured front tooth on 7/25/24 and given a referral to have the tooth extracted. The facility did not schedule the appointment with the oral surgeon until 10/10/2024. The findings are: The facility policy titled Dental Services dated 1/2020 documented that the involved regulation 485.55 Dental Services is that a facility must provide or obtain from an outside resource, in accordance with S483.75(h) of this part routine and emergency dental services to meet the needs of each resident. Resident #56 was admitted with diagnoses including atrial fibrillation, dementia, and hypertension. The 7/9/24 Annual Minimum Data Set documented Resident #56 had moderately impaired cognition and was independent with eating and oral hygiene. The 7/12/22 Dental Care Plan documented to monitor for signs and symptoms of infection such as pain and swelling. The 7/23/24 Physician order documented a dental consult for a broken top front tooth. The 7/25/24 Dental progress note documented Resident #56's tooth #9 was recently fractured and the resident had discomfort upon eating. Resident #56 opted to have tooth #9 extracted and fabricate an upper removable partial denture to replace the missing dentition. Resident #56 to be referred to the Oral Surgeon for extraction of tooth #9. The 9/12/24 Dental progress note documented Resident #56 had been referred to the Oral Surgeon for extraction of fractured tooth #9 and was requesting approval from Dentistry and once approved, the facility was to schedule the appointment. The 9/19/24 Dental progress documented Oral Surgeon approval was received from Dentistry and the facility was to schedule an appointment. On 10/03/24 at 11:29 AM, Resident #56 was observed in their room sitting up in their bed and stated that their top front tooth broke and they were having a lot of pain on the left side of their mouth when they bit down, and it was sore because of back tooth pain. Resident #56 opened their mouth, and it was observed that the top tooth was broken. Resident #56 stated they told staff that they had pain, and no one was doing anything about it. During an interview 10/08/24 at 12:32 PM, Resident #56 stated they had not seen the dentist yet and continued to have slight pain when eating. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/08/24 at 4:32 PM, Licensed Practical Nurse Manager #5 stated that there had been no dental appointment scheduled for Resident #56. They stated when there was an appointment scheduled, they received an email. The 10/9/24 Appointments/Scheduling progress note at 8:07 AM by Staff #22 documented the writer contacted Dentistry on 10/9/24 @ 8:06 AM to schedule an appointment for Resident #56 and they did not have any upcoming availability. The writer contacted the Dentist to reissue oral surgeon approval with another provider. During an interview on 10/09/24 01:11 PM, the Director of Nursing stated that Staff #22 did not schedule the appointment and did not write a note to indicate attempts to schedule an appointment. The 10/10/24 Appointments/Scheduling progress note documented oral surgery appointment was scheduled for 10/14/24. During an interview on 10/10/24 at 11:05 AM, Staff #22 stated they received the approval from the Dentist to schedule an appointment with the oral surgeon. Staff #22 stated it was their error because they tried to make an appointment prior to going to vacation but did not document the attempt to make an appointment. They stated no one followed up. During an interview on 10/11/24 at 12:25 PM, the Dentist stated they saw Resident #56 in July of 2024 for upper front broken tooth and discomfort while eating and requested a referral to see the Oral Surgeon for an extraction of the broken tooth, and when they did not get the approval back, they followed up. The Dentist stated that once the facility received the approval notification from them, the appointment should have been scheduled immediately. The Dentist stated when they examined Resident #56 on 10/10/24, Resident #56 complained of slight discomfort from food impaction and biting down. 10 NYCRR 415.17(b)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49364 Based on observation and interview conducted during the recertification survey from 10/3/24 through 10/11/24 the facility did not ensure food was stored in accordance with professional standards for food safety practice. Specifically, 1. Foods stored in nutrition and storage refrigerators were not labeled and dated. 2. Storage refrigerator meat was observed with Jello on the same shelf; and 3. staff were observed touching unsanitary surfaces and equipment with gloved hands, then preparing food without changing their gloves. Findings include: Undated policy and procedure titled Food Inventory, Receiving and Storage documented each food item must be labeled and dated, and all raw meats must be stored below all other items in the refrigerator. An initial tour of the kitchen was conducted on 10/03/24 at 9:26 AM and the following were observed: - Apple sauce in plastic containers on a tray in the nutrition refrigerator labeled as AS and was not dated. - Slice meats and yellow cheese were together on the same shelf in the storage refrigerator, also small packages of yellow cheese in (3 separate plastic wraps) were not dated and labeled. - Frozen meat was stored with 4 ounces of ice cream on the same shelf in the freezer, the frozen meat was not labeled and dated. - A container of coleslaw in the Cook's refrigerator was not labeled and dated. A second tour of the kitchen with observation of the steam table and tray line was conducted on 10/7/2024 at 11:34 AM, and the following were observed: - at 11:40 AM, Food Service Worker #8 was wearing gloves, opened the door to the storage closet, removed coffee cups and lids, returned to the tray line and started to pour coffee into the cups for the residents with the same gloves, did not remove gloves and wash their hands. - at 11:47 AM, Food Service Worker # 9 went outside of the tray line wearing gloves and returned with the same gloves and started to serve the residents their food. - at 11:55 AM, Food Service Worker #10 removed the ice scoop, went into the walking refrigerator to get butter, and returned to the tray line to continue serving the residents food, did not change their gloves and wash their hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 11:57 AM, the [NAME] was testing the temperatures of foods on the steam table and did not sanitize the food thermometer after each testing of foods with alcohol wipes, but cleaned the thermometer each time with a dish cloth. In addition, the [NAME] removed gloves, applied clean gloves and did not sanitize their hands. - 18 sandwiches of different variety were not dated and labeled and were on the tray line. - Juices in plastic containers not labeled, some containers labeled A verified by kitchen staff meaning apple juice and the others were unlabeled. During an interview on 10/07/24 at 12:09 PM, the Director of Food Services instructed Food Service Workers #8, # 9, # 10 and the [NAME] to remove their gloves and wash their hands after they were observed touching other surfaces with the same gloves and touching the food for the residents. The Director of Food Service stated they were responsible for overseeing the day-to-day operation of the kitchen and the staff, which included ordering of the foods and in-services of the kitchen staff on hand hygiene practices. The Director of Food Services stated if the foods were labeled, it would make the tray line move faster. In addition, the Food Service Director stated the food thermometer should have been sanitized using alcohol wipes. During an interview on 10/07/24 at 12:30 PM, the Dietitian stated their job description did not involve supervision of the Food Service Director and the Food Service Workers. Moreover, the dietitian stated the Food Services Director was responsible for the Kitchen staff and providing education in food handling. 10 NYCRR 415.14 (h)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49364 Based on observation, record review and interview conducted during the recertification survey on 10/03/24 through 10/11/24 the facility did not ensure proper disposal of garbage and refuse. Specifically, the dumpsters/compactors on the exterior of the building was not maintained in a sanitary condition to prevent the harborage and feeding of pests. The findings are: Undated policy titled Waste Management Policy and Procedure revealed the facility should ensure proper management in handling, storage and disposal of all waste generated to protect residents, staff, and visitors. In addition, waste must be in containers that are leak-proof and secured. During an observation on 10/07/24 at 11:55 AM, a mouse was seen running back and forth in the kitchen. During an observation on 10/10/24 at 10:15 AM, the dumpster/compactor was uncovered and the lid was missing. During an observation on 10/10/24 at 10:18 AM, there was a bag with garbage on the ground between the dumpsters. A review of the facility's pest control log dated 5/28/24 through 9/24/24 revealed the kitchen was treated for pest management. During an interview on 10/10/24 at 10:20 AM, the Food Service Director stated the dumpster was uncovered and should have been closed. The Food Service Director stated they were not sure how long the dumpster was unclosed and the lid was missing. During an interview on 10/10/24 at 1:23 PM, the Director of House Keeping/Laundry stated they were responsible for the facility to be clean and stated the dumpsters should have not been left opened. The Director of House Keeping/Laundry stated they would check the dumpsters once a week on Mondays to ascertain they were secure but did not check on Monday 10/07/24. During an interview on 10/11/24 at 11:39 AM, the Administrator stated their role was making any changes for garbage pick- up more frequently and if the facility needed more dumpsters. The Administrator stated the dumpsters should have been covered, stated they did environmental checks twice weekly and was not aware of the dumpster been uncovered and missing a lid. The Administrator stated they approved the policy and procedure for Waste management, of which was undated and not signed. 10 NYCRR 415.14(h)

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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. 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/03/24 to 10/11/24, the facility did not ensure that infection control prevention practices and procedures were maintained by 3 of 4 nurses (Registered Nurse #3 and Licensed Practical Nurse #2 and Licensed Practical Nurse #1) during the medication administration observation. Specifically, 1) Registered Nurse #3 did not practice hand hygiene or sanitize vital signs equipment between residents, and touched a resident's eye lid with the eye dropper during administration. 2) Licensed Practical Nurse #2 did not practice hand hygiene or wipe down the blood pressure cuff prior to doing the resident's blood pressure and before placing it back into the vital signs machine basket. 3) Licensed Practical Nurse #1 was observed preparing Resident #98's medications and their long hair was observed going inside the medication cart, medication cups, and the nebulizer treatment box. Findings include: 1) During a medication administration observation on 10/08/24 at 8:38 AM, Registered Nurse #3 went into the dining room, without sanitizing their hands, to give Resident #80 their medication and take their vital signs. Resident #80 was eating breakfast and Registered Nurse #3 removed the yogurt and attempted to take the resident's blood pressure. Resident #80 was visibly upset, irritated, and yelling they wanted to eat breakfast. Registered Nurse #3 was unable to get the blood pressure, removed the cuff, and did not administer the medications. At 8:42 AM, Registered Nurse #3 went back to the medication cart, without sanitizing their hands or the blood pressure cuff, then proceeded to save Resident #80's medications by putting the 2 cups full of medications on top of each other and placing them in the top of the medication cart. At 8:45 AM, Registered Nurse #3 walked into the Resident #43's room without sanitizing their hands, proceeded to take the resident's temperature and then placed the thermometer on the resident's breakfast tray while they left the room to go get tissue from another resident's room. At 8:51 AM, Registered Nurse #3 was instilling eye drops into Resident #43's eyes. The resident was clinching their eyes shut and Registered Nurse #3 pried the resident's upper eye lid open and touched their eye lid with top of eye drop bottle to instill the eye drops. At 08:56 AM, Registered Nurse #3 left Resident #43's room and placed the thermometer into the vital signs machine basket without sanitizing the thermometer or sanitizing their hands, before proceeding to the next resident. During an interview on 10/09/24 at 3:53 PM, Registered Nurse #3 stated they were supposed to wash and/or sanitize their hands before and after each resident when giving medications and performing vital signs. Registered Nurse #3 stated that when instilling eye drops, the applicator should not touch the resident's eyes and/or eyelids because of infection control and that the proper way to administer eye drops was by instilling the eye drops in the lower lid without touching their eyelids. Registered Nurse #3 stated they should have wiped down the blood pressure cuff between each resident use and the thermometer should have been cleaned and not placed on the breakfast tray. 2) During a medication administration observation on 10/08/24 at 09:03 AM, Licensed Practical Nurse #4 was observed going into Resident #85 room with the vital signs machine and did not sanitize their hands or wipe down the blood pressure cuff prior to entering and exiting Resident #85's room and placed the blood pressure cuff into the vital signs machine basket. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/08/24 at 09:03 AM, Licensed Practical Nurse #4 stated that they are aware of the infection control prevention practices and normally would wipe down the blood pressure cuff and sanitize their hands, and mistakenly forgot to do it. During an interview on 10/11/24 at 01:06 PM, the Assistant Director of Nursing stated that during the medication administration trainings, the nurses were educated on hand hygiene and the importance of sanitizing the vital signs equipment to prevent infections. The Assistant Director of Nursing stated that nurse should not be going from resident to resident administering medications or doing vitals without performing infection control practices. 3) During a medication administration observation on 10/08/24 at 9:18 AM, Licensed Practical Nurse #1 was preparing Resident #98's medications, and their long hair was observed going inside the medication cart, medication cups, and the nebulizer treatment box. When interviewed at that time, Licensed Practical Nurse #1 stated they were aware that their long hair was going into the medication cup (that was filled with medications) and the ipratropium bromide (nebulizer) box. They stated that their hair going into the resident's medication was poor infection control practice. Licensed Practical Nurse #1 stated that they forgot to put their hair up and proceeded to take their hair tie off their wrist and tied their hair up into a bun. 10 NYCRR 415.19