STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335003	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emerald Peek Rehabilitation and Nursing Center	2000 East Main Street Peekskill, NY 10566

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 11/4/2024 to 11/8/2024, the facility did not ensure the resident's right to a sanitary environment. This was evident during environmental observation of 1 (3rd Floor) of 2 resident units. Specifically, the shared resident bathrooms between rooms [ROOM NUMBERS] and rooms [ROOM NUMBERS] were observed with a strong odor of urine on multiple occasions. The findings are: The facility policy titled Terminal Cleaning Complete Room Cleaning dated 1/5/2024 documented Housekeeping staff allowed the floor in resident rooms to dry after damp-mopping it with disinfectant. On 11/05/2024 at 11:05 AM and 11/06/2024 at 04:42 PM, the shared bathroom between rooms [ROOM NUMBERS] was observed with a strong odor of urine. The caulking around the bottom edge of the toilet bowl was stained a dark yellow/orange color. There were 2 broken tiles at the base of the toilet bowl. There were no obvious signs of urine on the toilet bowl or on the floor. Across the hallway, room [ROOM NUMBER] was observed with a strong odor of urine emanating from the far side of the room by the window. The closed door of the shared bathroom between rooms [ROOM NUMBERS] was opened and an intensely strong odor of urine was present. The toilet bowl was stained with yellow dried urine and the caulking at the base of the toilet bowl was stained a dark yellow/orange color throughout. On 11/07/2024 at 12:41 PM, Certified Nursing Assistant #5 was asked to observe the shared bathroom between rooms [ROOM NUMBERS]. Certified Nursing Assistant #5 stated the bathroom smelled like urine and mildew. There were 2 of 4 residents in the adjoining rooms that were able to use the toilet. Certified Nursing Assistant #5 stated Housekeeper #9 cleaned the resident bathrooms often and sprayed air freshener but did not clean these rooms yet today. After observing the strongest urine smell in room [ROOM NUMBER]'s bathroom, Certified Nursing Assistant #5 stated this bathroom smelled like urine on previous occasions. Certified Nursing Assistant #5 stated the bathroom probably smelled that way because the residents used it throughout the day, but the bathroom did not always have a foul odor. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/2024 at 12:56 PM, Housekeeper #9 was interviewed and stated they were responsible for cleaning resident bathrooms on the 3rd Floor several times a day with bleach and a 3M neutralizer chemical solution. The Director of Environmental Services prepared the neutralizing solution for the Housekeeping staff by mixing a concentrated form of cleaning solution with water and pouring it into spray bottles. Housekeeper #9 stated they cleaned the floors throughout the unit at least once daily. After observing the strong urine smell in room [ROOM NUMBER]'s bathroom, Housekeeper #9 stated they made the Director of Environmental Services aware a few weeks ago that this bathroom had a strong foul odor that did not go away with standard cleaning and neutralizing solutions. Housekeeper #9 stated no matter how much they clean the bathroom in room [ROOM NUMBER], one of the residents in the room had a behavior of not urinating in the toilet bowl and the urine smell persisted. On 11/08/2024 at 11:55 AM, the Director of Environmental Services was interviewed and stated the urine smell in room [ROOM NUMBER] and its bathroom shared with room [ROOM NUMBER] was a chronic issue the Housekeeping staff have tried to address since one of the residents was admitted to the facility a few months ago. The resident had a behavior of urinating in various areas of the room, including the wall, air conditioning/heating radiator unit, and floor. The resident was also known to urinate on the bathroom floor, walls, and all over the outside of the toilet bowl . The Director of Environmental Services observed the foul odor in room [ROOM NUMBER] and stated the facility bought special odor neutralizers to address the issue but ran out and needed to purchase more. The Housekeeping staff were instructed to pay special attention to room [ROOM NUMBER]. Housekeeper #9 mopped the room and cleaned the bathroom several times a day. The night Housekeeper also made sure to clean the room at least once on the night shift during their rounds throughout the facility. Using bleach intensified the smell and the facility's current floor cleaning solution did not mitigate the intensity of the urine smell. The Director of Environmental Services stated they ripped out and replaced the caulking and sealant around the toilet bowl several times, but this was not the root cause of the lingering smell. The Director of Environmental Services stated they informed their Regional Director of the facility's efforts to address the foul odor in room [ROOM NUMBER] and made them aware that the issue remained unresolved. The Interdisciplinary Team, including the Administrator and Director of Nursing, discussed the concern often in morning report. The Director of Environmental Services stated the resident may have been exhibiting inappropriate behavior by urinating throughout their room but was unsure whether behavioral interventions were developed to try and address the behavior. On 11/08/2024 at 01:01 PM, the Director of Nursing was interviewed and stated the Director of Environmental Services discussed the concerns with a strong odor of urine in room [ROOM NUMBER] during morning report several times. The Director of Nursing stated they made rounds on the units and was recently in room [ROOM NUMBER] but was unaware the resident was urinating in various areas of the room and not in the toilet bowl. The Director of Nursing stated they thought the resident had episodes of incontinence and, as a result, their clothes ended up smelling of urine. The resident was offered a urinal but threw it away and Nursing staff try to change the bed linens in the room more quickly to address the smell. More frequent showering was also offered to the resident but none of the interventions were effective in addressing the smell of urine in room [ROOM NUMBER] and shared bathroom. 10 NYCRR 415.5(h)(2)

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	335003	A. Building B. Wing	11/08/2024

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50766 Based on record review and interviews during the Recertification survey from 11/3/2024 to 11/8/24, the facility did not ensure that a complete preadmission screening for individuals with a mental disorder was conducted. This was evident for 1 of 24 residents (Resident #82) reviewed for Preadmission Screening and Resident Review (PASARR) out of 24 sampled residents. Specifically, the SCREEN DOH 695 form was incomplete and a determination of a resident's need for Level II services had not been documented. Findings include: Resident #82 arrived at the facility on 8/12/24 with diagnoses that included, chronic pain, bipolar disorder, and major depressive disorder. The resident refused to proceed with admission upon arrival at facility and was discharged against medical advice on 8/12/24. The facility policy titled PASRR dated 7/15/24 stated that it is the policy of the facility that all residents have the required pre-admission screen prior to admission to the facility, and any time that there is a significant change that has bearing on the resident's specialized service needs. Procedure: Prior to a Resident's admission, the Admissions Department/designed will obtain: A SCREEN and Level I referral since the resident was referred for rehabilitation. A level II if the Level referral indicates that the resident is known to be affected by serious mental illness/and/or mental retardation/developmental disability per the guidelines. During review of the SCREEN Form DOH-695 completed for Resident #82 dated 8/12/2024, the day of admission to the facility, the section Level 1 Review for Possible Mental Illness (MI), included Item #23 Does this person have a serious mental illness?. Item #23 was not completed. The Level 1 Review for Possible Mental Retardation/Developmental Disability (MRDD) section, which includes items 23-26, were not completed. The guideline on the SCREEN form documented that if item 23 or any of item 24-26 were marked YES, proceed to Categorical Determination (items 27-30). Items 27-30 on the SCREEN form were not completed. The guideline for items 27-30 documented that if items 27-30 are marked NO, proceed to LEVEL II REFERRALS (Item 33). Item 33 was not completed. During an interview with the Admission Director on 11/08/24 at 01:37 PM, they stated that the PRI/Screens forms are sent to facility and reviewed by Admission Director. They stated that the SCREEN form is reviewed for patient and screener signatures. They also review SCREEN forms to determine if a level 2 evaluation was required. During the interview, the SCREEN form for Resident #82 was reviewed. The Director of Admissions stated that question #23, questions #24-#30 and question #33 were not answered. They were not aware why the SCREEN form for Resident #82 was not reviewed for completion. They stated that the SCREEN should have been returned to referring facility Social Work department with a request that the SCREEN form be accurately completed and returned for review. They stated accurately completed SCREEN forms are required prior to resident admission to ensure that services a resident may need are available prior to accepting admission. (continued on next page)

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	335003	A. Building B. Wing	11/08/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/24 at 02:17 PM with the Director of Nursing, they stated that SCREEN forms should be fully completed before a decision is made to accept a resident. Admission Director is responsible for ensuring completion of level I and level II information has been completed on SCREEN forms submitted to the facility. They stated that the SCREEN form for Resident #82, reviewed during interview, was not complete and should have been returned to facility requesting admission for completion. Any concerns on SCREEN forms or Level II reviews should be discussed with the Interdisciplinary team prior to admission to ensure that the Resident requesting admission to facility can receive the necessary services. 10 NYCRR 415.11(e)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 11/4/2024 to 11/8/2024, the facility did not ensure services provided met professional standards of quality. This was evident for 1 (Resident #20) of 4 residents reviewed for pressure ulcers out of 22 total sampled residents. Specifically, Licensed Practical Nurse #1 discontinued a physician ordered wound care treatment for Resident #20 without notifying the provider for an order to discontinue. The findings are: The facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 6/24/2024 documented the Physician will authorize pertinent orders related to wound treatments. The facility policy titled Pressure Injury Risk assessment dated [DATE] documented a skin assessment tool was used to document findings of skin inspections. Care plan interventions must be current and recognized standards of care. Report information in accordance with professional standards of practice. The facility Role of Licensed Practical Nurse Supervisor, signed by Licensed Practical Nurse #1 on 7/2023, documented the nurse will work in collaboration with physician and/or other health care professionals by sharing information relevant to changing the plan of care. Resident #20 had diagnoses of sacrococcygeal moisture-associated skin damage and in-house acquired deep tissue injury to the right heel. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #20 was severely cognitively impaired and had an unhealed unstageable deep tissue injury that was not present upon admission to the facility. The Comprehensive Care Plan related to right heel wound was initiated 9/19/2024 and documented Resident #20 should have treatments administered as ordered. Physician Order dated 10/25/2024 documented Resident #20 was ordered grey foam covered by kerlix tape to their coccyx and right heel every 48 hours. Both orders for treatment were discontinued on 11/6/2024 at 7:53 AM. Weekly Skin Observation dated 10/30/2024 documented Resident #20 had a deep tissue injury to their right heel and moisture-associated skin damage to their coccyx region. The Treatment Administration Record for 11/2024 documented the treatment order for grey foam to Resident #20's right heel and coccyx was discontinued on 11/6/2024. The Nursing Note dated 11/6/2024 documented Resident #20's wounds had resolved to the right heel and sacral coccyx region. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 11:38 AM, Licensed Practical Nurse #1, the medication and treatment nurse on Resident #20's unit, was interviewed and stated Resident #20 did not have any prescribed wound care treatment orders. Licensed Practical Nurse #1 stated they had no planned skin observations or treatments for Resident #20 because the resident did not have any open areas on their skin that required wound care. On 11/06/2024 at 02:20 PM, Certified Nursing Assistant #5 assisted with observing Resident #20's sacral area. Resident #20's coccyx was observed with a small open excoriated area. Resident #20's right heel was observed with a dressing to their right heel dated 11/4/2024. At 2:21 PM, Licensed Practical Nurse #1 entered Resident #20's room and stated the dressing on the resident's right heel was a protective dressing. Licensed Practical Nurse #1 removed the right heel dressing and Resident #20's right heel was observed with red, moist skin and a skin flap with an open area. Licensed Practical Nurse #1 stated Resident #20 was not on wound rounds and had not been receiving wound treatment for their right heel or sacral area. Licensed Practical Nurse #1 stated they would place Resident #20 on wound rounds for the Wound Care Nurse Practitioner to assess starting tomorrow, 11/7/2024. On 11/07/2024 at 05:08 PM, the Wound Care Nurse Practitioner was interviewed and stated Resident #20 had wound treatments ordered for their right heel and sacral/coccyx area. The Wound Care Practitioners stated they did not receive any calls from the facility or Licensed Practical Nurse #1 to inform them that wound care treatments were discontinued on 11/6/2024. The Wound Care Nurse Practitioner stated they would not have discontinued the wound care orders for Resident #20 on 11/6/2024 because the resident required ongoing wound treatment to the right heel and sacral/coccyx area for wounds that had not resolved. On 11/08/2024 at 12:41 PM, Licensed Practical Nurse #1 was interviewed and stated they did not speak with the Wound Care Practitioner or any other physician prior to discontinuing Resident #20's wound treatments for their right heel and coccyx/sacral area on 11/6/2024. Licensed Practical Nurse #1 stated they heard from the Director of Nursing that Resident #20's wounds might be resolving and the placed the order to discontinue treatment without observing Resident #20's wounds or speaking with the Wound Care Nurse Practitioner. Licensed Practical Nurse #1 stated it was not in their scope of practice to be able to assess a resident's wounds, order treatments, or discontinue treatments without consulting a physician. On 11/08/2024 at 01:27 PM, the Director of Nursing was interviewed and stated it was not the facility policy or a standard of practice for Licensed Practical Nurses to order or discontinue wound care treatments without first consulting a physician or nurse practitioner. 10 NYCRR 415.11(c)(3)(i)

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	335003	A. Building B. Wing	11/08/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 11/4/2024 to 11/8/2024, the facility did not ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing. This was evident for 1 (Resident #20) of 4 residents reviewed for pressure ulcers. Specifically, Licensed Practical Nurse #1 discontinued a physician ordered wound care treatment for Resident #20 without notifying the provider and getting an order to discontinue. The findings are: The facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 6/24/2024 documented the Physician will authorize pertinent orders related to wound treatments. The facility policy titled Pressure Injury Risk assessment dated [DATE] documented a skin assessment tool was used to document findings of skin inspections. Care plan interventions must be current and recognized standards of care. Report information in accordance with professional standards of practice. Resident #20 had diagnoses of sacrococcygeal moisture-associated skin damage and in-house acquired deep tissue injury to the right heel. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #20 was severely cognitively impaired and had an unhealed unstageable deep tissue injury that was not present upon admission to the facility. The Comprehensive Care Plan related to right heel wound was initiated 9/19/2024 and documented Resident #20 should have treatments administered as ordered. Physician Order dated 10/25/2024 documented Resident #20 was ordered grey foam covered by kerlix tape to their coccyx and right heel every 48 hours. Both orders for treatment were discontinued on 11/6/2024 7:53 AM. Weekly Skin Observation dated 10/30/2024 documented Resident #20 had a deep tissue injury to their right heel and moisture-associated skin damage to their coccyx region. The Treatment Administration Record for 11/2024 documented the treatment order for grey foam to Resident #20's right heel and coccyx was discontinued on 11/6/2024. The Nursing Note dated 11/6/2024 documented Resident #20's wounds had resolved to the right heel and sacral coccyx region. (continued on next page)

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	335003	A. Building B. Wing	11/08/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/2024 at 11:38 AM, Licensed Practical Nurse #1, the medication and treatment nurse on Resident #20's unit, was interviewed and stated Resident #20 did not have any prescribed wound care treatment orders. Licensed Practical Nurse #1 stated they had no planned skin observations or treatments for Resident #20 because the resident did not have any open areas on their skin that required wound care. On 11/06/2024 at 11:43 AM, Certified Nursing Assistant #5, assigned to Resident #20, was interviewed and stated they planned to place Resident #20 back into bed at approximately 2 PM and would coordinate an observation of the resident's sacrum and right heel. On 11/06/2024 at 02:20 PM, Certified Nursing Assistant #5 assisted with observing Resident #20's sacral area. Resident #20's coccyx was observed with a small open excoriated area. Resident #20's right heel was observed with a dressing to their right heel dated 11/4/2024. At 2:21 PM, Licensed Practical Nurse #1 entered Resident #20's room and stated the dressing on the resident's right heel was a protective dressing. Licensed Practical Nurse #1 removed the right heel dressing and Resident #20's right heel was observed with red, moist skin and a skin flap with an open area. Licensed Practical Nurse #1 stated Resident #20 was not on wound rounds and had not been receiving wound treatment for their right heel or sacral area. Licensed Practical Nurse #1 stated they would place Resident #20 on wound rounds for the Wound Care Nurse Practitioner to assess starting tomorrow, 11/7/2024. On 11/07/2024 at 05:08 PM, the Wound Care Nurse Practitioner was interviewed and stated Resident #20 had wound treatments ordered for their right heel and sacral/coccyx area. The Wound Care Practitioners stated they did not receive any calls from the facility or Licensed Practical Nurse #1 to inform them that wound care treatments were discontinued on 11/6/2024. The Wound Care Nurse Practitioner stated they would not have discontinued the wound care orders for Resident #20 on 11/6/2024 because the resident required ongoing wound treatment to the right heel and sacral/coccyx area for wounds that had not resolved. On 11/08/2024 at 12:41 PM, Licensed Practical Nurse #1 was interviewed and stated they did not speak with the Wound Care Practitioner or any other physician prior to discontinuing Resident #20's wound treatments for their right heel and coccyx/sacral area on 11/6/2024. Licensed Practical Nurse #1 stated they heard from the Director of Nursing that Resident #20's wounds might be resolving and the placed the order to discontinue treatment without observing Resident #20's wounds or speaking with the Wound Care Nurse Practitioner. Licensed Practical Nurse #1 stated it was not in their scope of practice to be able to assess a resident's wounds, order treatments, or discontinue treatments without consulting a physician. On 11/08/2024 at 01:27 PM, the Director of Nursing was interviewed and stated it was not the facility policy or a standard of practice for Licensed Practical Nurses to order or discontinue wound care treatments without first consulting a physician or nurse practitioner. 10 NYCRR 415.12(c)(1)

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	335003	A. Building B. Wing	11/08/2024

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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. 50766 Based on record review and interview conducted during the recertification survey from 11/4/2024 to 11/8/2024, the facility did not ensure Annual Performance Reviews were completed at least once every 12 months. Specifically, the facility was unable to provide Annual Performance Reviews for 5 of 5 Staff Members (#11, #12, #13, #14, #15) reviewed. The findings are: The facility policy titled Job Performance Review, dated 10/01/2024, stated: The job performance of each employee shall be reviewed and evaluated at least annually. During an interview with Assistant Director of Nursing/Nurse Educator on 11/06/24 at 4:14 PM, they stated the facility had just resumed Annual Performance Appraisals for nursing staff. The Assistant Director of Nursing/Nurses Educator stated they were unable to provide performance appraisals for the 5 staff members requested (#11, #12, #13, #14, #15). During an interview with the Administrator on 11/08/24 at 3:17 PM, the Administrator stated the facility had not completed staff Annual Performance Appraisals for the last few years. They stated the facility was in the process of resuming Annual Performance Appraisals at the current time and they were aware that the Assistant Director of Nursing/Nurse Educator was unable to provide the requested Annual Performance Appraisals requested during the survey. 10NYCRR 415.26 (c)(2)(iii)

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	335003	A. Building B. Wing	11/08/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50766 Based on observation, record review, and interviews conducted during the recertification and abbreviated survey (NY00338157) conducted 11/4/2024 to 11/8/2024, the facility did not ensure they provided medications and/or biologicals, as ordered by the prescriber, to meet the needs of 1 (Residents #184) of 2 residents reviewed for Pharmacy Services. Specifically, Resident #182 did not receive methylprednisolone (a medication used to treat lupus) on 3/30/24 and 3/31/24. The medication was not acquired from the pharmacy and administered as ordered. Findings include: The facility policy titled Medication Administration dated 10/05/2024 stated: Medication shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time. If medication is unavailable from the pharmacy or E-box or First Done Machine (Med-bank) for the scheduled time, the practitioner will be contacted for further instructions. Resident #184 was admitted [DATE] with diagnoses including fracture of one rib, fracture of surgical neck of left humerus, and systemic lupus erythematosus. The Admission Minimum Date Set Admission, dated 3/31/24, documented Resident #184 had intact cognition. A Physician order dated 3/29/24 documented methylprednisolone oral tablet 2 milligrams. Give 6.5 tablet by mouth one time a day for systemic lupus starting 3/30/24. Resident #184's Medication Administration Record for 3/30/2024 and 3/31/2024 documented methylprednisolone oral tablet 2 milligram, give 6.5 tablet by mouth one time a day for systemic lupus, starting 3/30/24 was not administered. The documented reason was Code 9: other/see Nurse notes. A review of Nurse Progress Notes and Physician notes from 3/29/24 to 3/31/24 did not include documentation related to methylprednisolone administration concerns. There were no other Progress Notes related to medications being unavailable or physician notification of medications not being administered as ordered. During a telephone interview with Resident #184's family member on 11/06/24 at 9:36 AM, they stated that Resident #184 did not received steroid (methylprednisolone) during their stay at the facility. The family member stated a facility staff member told them the facility would not have the medication in-house until the following Wednesday. The family member stated that resident and family decided to have resident transferred to the hospital on 3/31/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335003	A. Building B. Wing	11/08/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the facility Administrator on 11/08/24 at 10:14 AM, they stated Resident #184's medications were ordered the evening of 3/29/24. They stated that the expectation was that the medications ordered would be delivered to facility the next morning which did not occur. The Administrator stated that the medication (methylprednisolone) was not administered on 3/30/24 or 3/31/24. The Administrator stated the facility Medical Director was not notified on 3/30/24 regarding missing medications. They stated that there was a failure in communication between facility and the pharmacy. During an interview with the Pharmacist on 11/08/24 at 12:47 PM, they stated the order received was for methylprednisolone 2 milligram tablet, to give 6.5 tablets by mouth one time a day. Pharmacist stated that the 2 milligram tablets were not available and the closest dose available would be 4 milligram tablets and made a recommendation to give three 4 milligram tablets to equal 12 milligrams. They stated that when the pharmacist was unable to reach the facility nurse supervisor to discuss recommendations, the follow-up call should have remained in the pharmacy queue so further follow-up could be completed. This did not occur which led to no further follow-up with the facility. The Pharmacist stated the policy was not followed correctly and communication did not continue, and the methylprednisolone was not delivered to facility. During an interview on 11/08/24 at 02:05 PM with the Director of Nursing, they stated that the medication (methylprednisolone) not being available and communication with the pharmacy was a concern. They stated that the facility did not stock methylprednisolone tablets in E-box or First Done Machine (Med-bank). They stated communication did not occur between nurse staff during change of shift rounds on 3/30/24 regarding Resident #184 not receiving methylprednisolone due to not being received from pharmacy during morning delivery. The evening nurse on duty did not know to contact the pharmacy when it was not delivered in afternoon delivery. 10 NYCRR 415.18(a)

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	335003	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Emerald Peek Rehabilitation and Nursing Center	2000 East Main Street Peekskill, NY 10566

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 47626 Based on record review and interviews during a survey from 11/4/24-11/8/24, the facility did not ensure each resident's drug regimen was free from unnecessary drugs, use for 1 (Resident #73) of 5 residents reviewed for unnecessary drugs. Specifically, Resident #73 had an order for Tramadol 50 milligrams three times a day for a pain scale of 5-10 and was administered 12 times from 11/1/24-11/6/24 with a pain scale less than 5. Findings included: Resident # 73 had diagnosis including Cerebral infarction, Aphasia, and Type 2 diabetes. A Policy and Procedure titled Medication Administration dated 10/5/2024 documented Medication must be administered in accordance with orders, including any required time frames. If a dosage is believed to be inappropriate or excessive for the resident, the person preparing or administering the medication will contact the resident's attending physician or the facility medical director to discuss concerns. A quarterly Minimum Data Set (an assessment tool) dated 10/1/2024 documented the resident's cognition was severely impaired. The resident required supervision or touching assistance with eating and was dependent on staff with all other care. The resident received insulin all 7 days during the look back period. Additionally received an opioid. A physician order dated 10/18/2024 documented Tramadol 50 milligrams, give 1 tablet every 8 hours for pain scale of 5-10. The November 2024 Medication Administration Record documented Resident #73 received Tramadol 50 milligram with a documented pain scale of 0 (zero) at 6:00 AM on 11/5/24 and 11/6/24; at 2:00 PM on 11/1/24, 11/2/24, 11/3/24, and 11/5/24; and at 10:00 PM on 11/2/24 and 11/5/24. A review of the Narcotics book documented that Tramadol 50 milligrams was signed out every 8 hours standing from 11/1/2024 to current. The drug regimen review recommended for the physician to evaluate the use of Tramadol, dated 9/19/24 the Medical Director responded the resident moaned and was nonverbal, the current dose was required with no gradual dose reduction. During an interview with Registered Nurse #8 on 11/06/24 at 10:03 AM they stated it was a standing order for Tramadol and they did not know why the pain scale was included. The resident was nonverbal and would be unable to use the pain numerical pain scale. During an interview with Licensed Practical Nurse Unit Manager #7 on 11/06/24 at 10:05 AM, they stated they believed the order may have changed from an as needed (PRN) order to a standing order. They stated they needed to get the order clarified. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Physician #1 on 11/08/24 at 10:21 AM, they stated they would not write a standing order with a pain scale, but if the order had a pain scale it should have been followed. If the order was to give Tramadol for pain scale of 5-10, and the resident's pain scale was 0, then the nurse should have called them prior to giving the medication. During an interview with Physicians Assistant #9 on 11/08/24 at 10:31 AM, they stated they were the last person who had signed off on the resident's medications on 10/18/24. The resident required the medication for chronic pain, was nonverbal and unable to provide a numeric pain scale. The order should have been clarified by the nurse. 415.12(l)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50816 Based on observation and interview conducted during a recertification survey from 11/04/24 to 11/08/2024, the facility failed to provide separately locked, permanently affixed compartments for storage of controlled substances on 1 of 2 facility units (Third Floor) reviewed for drug storage. Specifically, injectable Ativan (a controlled substance) was not stored in a double locked permanently affixed compartment. The findings are: Facility policy on Medication Labeling Storage dated 10/5/2024 documented the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Controlled substances (listed as Schedule II-4 of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. During an observation of the third-floor medication room at 10:16 AM on 11/6/2024, a clear plastic narcotic box was inside the medication refrigerator. The narcotic box had 2 keys. License Practical Nurse #2 attempted to but was unable to open the narcotic box with her keys. License Practical Nurse #2 removed the narcotic box from the refrigerator; it was not affixed inside the medication refrigerator. Inside the narcotic box were six (6) injectables of Ativan for Resident #4. When interviewed on 11/6/2024 at 10:16 AM, License Practical Nurse #2 was not able to provide an answer as to why the narcotic box was not affixed to the refrigerator. When interviewed on 11/6/2024 at 11:23 AM, the Director of Nursing stated the narcotic box inside the medication refrigerator should have been permanently affixed and not removable. 10 NYCRR 415.18 (e) (1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on observation, record review, and interviews conducted during a recertification survey from 11/4/2024 to 11/8/2024, the facility did not ensure infection control and prevention practices were maintained. This was evident for 2 (Resident #11 and #14) residents during a dining observation and 2 (Resident #70 and #38) of 4 residents during medication administration observation. Specifically, 1) Certified Nurse Aide #16 was observed feeding Residents #11 and #14 without performing hand hygiene between residents, and 2) Licensed Practical Nurse #1 was observed administering medication to Residents #70 and #38 without performing hand hygiene after touching other items in the room and administering eye drops. The findings are: 1) Residents #11 and #14 both had diagnoses of dysphagia and dementia. During a lunch meal observation in the Main Dining Room on 11/4/2024 at 12:43 PM, Certified Nurse Aide #16 picked up a spoon and fed Resident #11. Certified Nurse Aid #16 then set the spoon down, turned and picked up Resident #14 ' s spoon with the same hand and fed Resident #14. Certified Nurse Aide #16 continued to use the same hand to feed both residents without performing hand hygiene in between picking up and setting down the different spoons. During an interview on 11/06/2024 at 03:32 PM, Certified Nurse Aide #16 stated they fed Resident #11 and Resident #14 at the same time because there were not enough people to help feed those residents. Certified Nurse Aide #16 stated they did not realize they fed both residents with the same hand and should have sanitized their hands in between feeding each resident. During an interview on 11/06/2024 at 05:03 PM, the Infection Preventionist stated staff were not typically allowed to feed 2 residents at the same time. Certified Nurse Aide #16 should have sanitized their hands in between feeding residents and should not have used the same hand to feed both residents. 2) The facility policy titled Administering Medications dated 9/26/2024 documented staff follow established infection control procedures (handwashing, antiseptic technique, gloves, isolation precautions) for the administration of medications. During medication administration on 11/6/2024 from 9:17 AM to 10:13 AM, on 3rd Floor East, the following was observed: - Licensed Practical Nurse #1 prepared medication for Resident #70 at the medication cart, entered Resident #70 ' s room, touched the resident ' s wheelchair and Hoyer lift pad, did not perform hand hygiene, and administered oral medications to Resident #70. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Licensed Practical Nurse #1 donned a pair of gloves, entered Resident #38 ' s room with oral medications and eye drops. At Resident #38 ' s bedside, while waking up the resident and assisting the resident to a sitting position, Licensed Practical Nurse #1 touched and pulled the disposable incontinence pad underneath the resident. Licensed Practical Nurse #1 proceeded to get a spoon from the medication cart and with the spoon, administered oral medications to Resident #38 then grabbed a bottle of eyedrops, and administered eyedrops to Resident #38. Licensed Practical Nurse #1 did not perform hand hygiene in between touching the resident ' s bedding, administering the oral medications, and prior to administering eyedrops. On 11/06/2024 at 10:14 AM, Licensed Practical Nurse #1 was interviewed and stated they should have performed hand hygiene after touching other objects and prior to and after administering medications to Residents #70 and #38. Licensed Practical Nurse #1 stated they were aware of the infection control and prevention practices and forgot to do so during medication administration. 10 NYCRR 415.19(a)(1-3) 50816