STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335024	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Terrace Care Center	640 West Broadway Long Beach, NY 11561

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and staff interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024 the facility did not ensure that all alleged violations, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in a serious bodily injury, to the New York State Department of Health. This was identified for one (Resident #48) of three residents reviewed for skin conditions and one (Resident #83) of seven residents reviewed for Accidents. Specifically, 1) Resident #48 sustained a scrotal avulsion (a forcible tearing off the skin of the scrotum) on 1/25/2024 requiring surgical intervention. The cause of the injury was unknown, and the facility did not report the injury of unknown origin to the New York State Department of Health. 2) Resident #83 sustained a discoloration to the right eye and right forehead on 6/22/2024. Resident #83's injury was of unknown origin and was not reported to the New York State Department of Health. The findings are: The facility's Resident Accident/Significant Event policy dated 6/17/2019 documented that a significant event shall be defined as an unintended event resulting in serious bodily harm, such as fracture, laceration that requires closure, second or third-degree burns, or any injury requiring hospital admission. If an accident causes injury or presents the potential for injury or recurrence, the facility will investigate in conjunction with the facility's quality improvement program within five calendar days. Any identified neglect or abuse relating to the accident will be promptly reported to the New York State Department of Health. All accident reports will be screened for evidence of failure to follow the care plan, delay in assessment/treatment, and injuries of unknown origin. The policy did not specifically state the incident must be reported within 2 hours if the event involved suspected abuse or caused serious bodily injury. Resident #48 was admitted with diagnoses including Cerebrovascular Accident, Non-Alzheimer's Dementia, and Psychotic Disorder. The 1/15/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 99, indicating the resident could not complete the interview. The Minimum Data Set assessment documented the resident had behavior symptoms that were not directed toward others. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for Behavioral Symptoms-Disruptive or Dangerous to Self or Others effective 6/23/2014 and last updated 7/1/2024 documented the resident has a history of self-injurious behavior. A care plan update on 1/22/2024 documented that Resident #48 was verbally and physically aggressive and was kicking and punching staff during evening care. The interventions included utilizing behavior management strategies, monitoring early warning signs of problem behaviors, and escorting the resident to a less stimulating environment as needed. A nursing progress note dated 1/25/2024 at 8:10 PM, written by Registered Nurse #1, documented Resident #48 was noted with a scrotal wound; the skin came off the sack with moderate bleeding. The nurse cleaned the wound with normal saline, applied bacitracin, and then covered the wound with a dry sterile dressing. The Physician was made aware, and the resident was transferred to the hospital. A nursing progress note dated 1/26/2024 at 10:04 AM, written by Registered Nurse #5, documented Resident #48 was admitted to the hospital and was transferred to the operating room for the surgical repair of the Scrotal Avulsion. A nursing progress note dated 1/26/2024 at 9:34 PM, written by Registered Nurse #1, documented the resident returned from the hospital with a diagnosis of Scrotal Avulsion. The resident's scrotal wound area was noted with sutures. Certified Nursing Assistant #1, the assigned Certified Nursing Assistant, was interviewed on 6/28/2024 at 11:52 AM. Certified Nursing Assistant #1 stated the resident has aggressive behaviors and would fight with caregivers by hitting, kicking, and punching the caregivers during care. Certified Nursing Assistant #1 stated that the resident also has a behavior of fondling themselves. Registered Nurse #1, the 3:00 PM-11:00 PM supervisor, was interviewed on 7/1/2024 at 12:26 PM. Registered Nurse #1 stated Resident #48's scrotal wound was identified during care in the evening shift on 1/25/2024. Certified Nurse Assistant #2 reported there was blood in the resident's brief. Upon assessment, the scrotal area had opened skin and was bleeding. Registered Nurse #1 notified the Physician, and the resident was transferred to the hospital for evaluation. Registered Nurse #1 stated they did not initiate an investigation to identify how the resident sustained the scrotal injury. Registered Nurse #1 stated that Resident #48 occasionally placed their hand in their brief, which they believed to be the cause of the injury. There were no reports of the resident being aggressive during care on 1/25/2024. Certified Nursing Assistant #2, who was assigned to Resident #48 on 1/25/2024 during the 3:00 PM-11:00 PM shift, was interviewed on 7/1/2024 at 2:24 PM. Certified Nursing Assistant #2 stated on 1/25/2024, they transferred Resident #48 back to bed via a mechanical lift with another Certified Nursing Assistant and provided care. The resident did not exhibit aggressive behaviors on 1/25/2024 during the evening shift. Certified Nursing Assistant #2 stated when they removed the resident's brief, they saw blood in the brief. Certified Nurse Assistant #2 denied incident or injury during care. There were no problems with the mechanical lift transfer. Certified Nursing Assistant #2 immediately reported the injury to Registered Nurse #1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 7/2/2024 at 8:30 AM. The Director of Nursing Services stated I never saw anything like this kind of injury. I cannot imagine this kind of injury could be caused by the resident just putting their hands in their pants. The Director of Nursing Services stated an investigation was not initiated because there were no known falls or accidents. The Director of Nursing Services stated they did not consider abuse as a possible cause of Resident #48's injury at the time. The Director of Nursing Services stated the resident's injury was of unknown origin and should have been reported to the New York State Department of Health. Registered Nurse Risk Manager #1 was interviewed on 7/3/2024 at 8:10 AM and stated an investigation related to the resident's injury was not completed because Resident #48 had a history of fondling their (Resident #48's) scrotum which could have caused the injury. Registered Nurse Risk Manager #1 stated that an investigation should have been completed to rule out abuse and the incident should have been reported to the New York State Department of Health within two hours because the injury sustained by the resident was a significant injury of unknown origin. 48827 2) The facility's policy titled Resident Accident/Significant Event dated 06/17/2019 documented that any identified neglect or abuse relating to the accident will be promptly reported to the Department of Health. Resident #83 was admitted with diagnoses including Dementia, Type 2 Diabetes Mellitus, and Anxiety. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, which indicated the resident had severely impaired cognition. The Falls Comprehensive Care Plan dated 7/25/2022 and revised on 9/27/2023 documented Resident #82 had a history of falls. The interventions included bed alarm and monitoring for increased confusion, agitation, or behavior changes. A nursing progress note, written by Registered Nurse #3 on 6/22/2024 at 8:05 AM, documented Certified Nurse Assistant #3 reported the resident had a blue/purple discoloration to the right eye. The resident was unable to verbalize or recall what happened. A nursing progress note, written by Registered Nurse Supervisor #4 on 6/22/2024 at 8:30 AM, documented Resident #83 was noted with discoloration to the right eye and right forehead. The resident was unable to describe what happened. Resident #83's family member declined to transfer the resident to the emergency room for a Computerized Tomography (CT) scan. The Accident and Incident report dated 6/22/2024 at 7:30 AM documented that Resident #83 had a discoloration to the right eye and right forehead. The resident was unaware of what happened and the incident was unwitnessed. The written statements obtained from nursing staff during the day shift indicated no one observed a fall or an incident that may have resulted in the identified discoloration. The Accident Investigation Report, Summary of investigation, dated 6/27/2024 documented the nature of the incident: Fall- Discoloration to Right Eye and Forehead. The summary documented there was no sufficient evidence of resident abuse, mistreatment, or neglect. The summary was signed by the facility Administrator and the Director of Nursing Services. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #3 was interviewed on 7/1/2024 at 2:11 PM and stated they were not assigned to care for Resident #83. They saw Resident #83 in the hallway walking to the dining room on 6/22/2024 during the 7:00 AM to 3:00 PM shift. They noticed the resident had discoloration on the right eye and reported the discoloration to the Nurse. Certified Nursing Assistant #2 was interviewed on 7/1/2024 at 2:19 PM and stated that they were assigned to care for Resident #83 on 6/22/2024 but they did not see Resident #83 until after Certified Nurse Aide #3 reported the bruise on the resident's right eye. Registered Nurse #3 was interviewed on 7/3/2024 at 10:14 AM and stated they observed Resident #83 in bed sleeping when they conducted their morning rounds on 6/22/2024. Registered Nurse #3 stated they were unable to see the resident's face and did not observe the bruise to the resident's right eye. Registered Nurse Supervisor #4 was interviewed on 7/3/2024 at 8:41 AM and stated that when they were notified of the discoloration to the resident's forehead on 6/22/2024, they called the Director of Nursing and investigated the incident. Registered Nurse Supervisor #4 stated they assumed Resident #83 fell . Registered Nurse Supervisor #4 stated they obtained statements from the nursing staff on the day shift. Registered Nurse Supervisor #4 stated the incident occurred on the weekend and they left the report documents in the Risk Manager's mailbox. The Risk Manager was interviewed on 7/3/2024 at 8:52 AM and stated they reviewed Resident #83's incident report on 6/24/2024. The Risk Manager stated they usually do not investigate the previous shift staff and did not know if the previous shift staff should have provided statements related to the resident's injury. The Risk Manager stated the Director of Nursing Services was responsible for reporting injuries of unknown origin to the New York State Department of Health. The Director of Nursing Services was interviewed on 7/3/2024 at 9:14 AM and stated they were informed of Resident #83's injury on the morning of 6/22/2024. The Director of Nursing Services stated the resident's assigned nursing staff from the previous shifts should have been interviewed to rule out abuse for the injury of unknown origin. The Director of Nursing stated they were responsible for reporting an injury of unknown origin to the New York State Department of Health. The Director of Nursing further stated they should have reported Resident #83's injury of unknown origin to the New York State Department of Health because the cause of the injury was unknown and they were unable to determine how the resident sustained bruises. 10 NYCRR 415.4(b)(2)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and staff interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024 the facility did not ensure that each allegation of abuse, neglect, exploitation, mistreatment, or injury of unknown origin was thoroughly investigated. This was identified for one (Resident #48) of three residents reviewed for skin conditions and one (Resident #83) of seven residents reviewed for Accidents. Specifically, 1) Resident #48 sustained a scrotal avulsion (a forcible tearing off the skin of the scrotum) that required surgical intervention on 1/25/2024. The cause of the injury was unknown. There was no investigation to determine the root cause of the injury. 2) Resident #83 sustained a discoloration to the right eye and right forehead on 6/22/2024. Resident #83's injury was of unknown origin. There was no investigation to determine the root cause of the injury. The findings are: 1) The facility's Accident/Significant Event policy dated 6/17/2019 documented that a significant event shall be defined as an unintended event resulting in serious bodily harm, such as fracture, laceration that requires closure, second or third-degree burns, or any injury requiring hospital admission. If an accident occurs that causes injury or presents the potential for injury or recurrence, the facility will investigate in conjunction with the facility's quality improvement program within five calendar days. All accidents, unexplained bruises, or injuries are reported to the charge nurse immediately. The charge nurse informs the Registered Nurse Supervisor. The policy then describes each step of the investigation process. Resident #48 was admitted with diagnoses including Cerebrovascular Accident, Non-Alzheimer's Dementia, and Psychotic Disorder. The 1/15/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 99, indicating the resident could not complete the interview. The Minimum Data Set assessment documented the resident had behavior symptoms that were not directed toward others. There were no skin conditions documented. A Comprehensive Care Plan for Behavioral Symptoms-Disruptive or Dangerous to Self or Others effective 6/23/2014 and last updated 7/1/2024 documented the resident has a history of self-injurious behavior. A care plan update on 1/22/2024 documented that Resident #48 was verbally and physically aggressive; the resident was kicking and punching staff as the Certified Nursing Assistant was performing evening care. The interventions included utilizing behavior management strategies, monitoring early warning signs of problem behaviors, and escorting the resident to a less stimulating environment as needed. A nursing progress note dated 1/25/2024 at 8:10 PM, written by Registered Nurse #1, documented Resident #48 was noted with a scrotal wound; the skin came off the sack with moderate bleeding. The nurse cleaned the wound with normal saline, applied bacitracin, and then covered the wound with a dry sterile dressing. The physician was made aware and the resident was transferred to the hospital. A nursing progress note dated 1/26/2024 at 10:04 AM, written by Registered Nurse #5, documented Resident #48 was admitted to the hospital and transferred to the operating room for surgery to repair the Scrotal Avulsion. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 1/26/2024 at 9:34 PM, written by Registered Nurse #1, documented the resident returned from the hospital with the diagnosis of Scrotal Avulsion. The resident's scrotal wound area was noted with sutures. Certified Nursing Assistant #1, Resident #48's assigned Certified Nursing Assistant, was interviewed on 6/28/2024 at 11:52 AM. Certified Nursing Assistant #1 stated the resident has aggressive behaviors during care. The resident would fight, hit, kick, and punch the caregivers and also kick the wheelchair. Certified Nursing Assistant #1 added that the resident also has a history of fondling (their scrotal area) themselves. Registered Nurse #1, the 3:00 PM-11:00 PM supervisor, was interviewed on 7/1/2024 at 12:26 PM. Registered Nurse #1 stated Resident #48's scrotal wound was identified during care in the evening shift on 1/25/2024. Certified Nurse Assistant #2 reported there was blood in the resident's brief. Upon assessment, the scrotal area had opened skin and was bleeding. Registered Nurse #1 notified the Physician and the resident was transferred to the hospital for evaluation. Registered Nurse #1 stated they did not initiate an investigation to identify how the resident sustained the scrotal injury. Registered Nurse #1 stated that Resident #48 occasionally placed their hand in their brief, which they believed to be the cause of the injury. There were no reports of the resident being aggressive during care on 1/25/2024. Certified Nursing Assistant #2, who was assigned to Resident #48 on 1/25/2024 during the 3:00 PM-11:00 PM shift, was interviewed on 7/1/2024 at 2:24 PM. Certified Nursing Assistant #2 stated on 1/25/2024, they transferred Resident #48 back to bed via a mechanical lift with another Certified Nursing Assistant and provided care. The resident did not exhibit aggressive behaviors on 1/25/2024 during the evening shift. Certified Nursing Assistant #2 stated when they removed the resident's brief, they saw blood in the brief. Certified Nurse Assistant #2 denied incident or injury during care. There were no problems with the mechanical lift transfer. Certified Nursing Assistant #2 immediately reported the injury to Registered Nurse #1. Physician #1, the Medical Director, was interviewed on 7/1/2024 at 2:59 PM and stated they could only speculate the cause of Resident #48's scrotal injury; the injury was most likely self-inflicted because the resident had a behavior of putting their hands in their brief I never saw anything like this, and I was surprised by the [scrotal avulsion] diagnosis. Physician #1/Medical Director stated they evaluated Resident #48 on 1/28/2024 after the resident returned from the hospital; however, they did not document the cause of injury. The Director of Nursing Services was interviewed on 7/2/2024 at 8:30 AM. The Director of Nursing Services stated the resident sustained Scrotal Avulsion and had to be transferred to the hospital for sutures. The resident had a history of putting their hands in their brief; however, I never saw anything like this kind of injury. I cannot imagine this kind of injury could be caused by the resident just putting their hands in their pants. The Director of Nursing Services stated an investigation was not initiated because there were no known falls or accidents. The Director of Nursing Services stated they did not consider abuse as a possible cause of Resident #48's injury at the time. The Director of Nursing Services stated the resident's injury was of unknown origin and should have been investigated to rule out abuse, neglect, and mistreatment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Risk Manager #1 was interviewed on 7/3/2024 at 8:10 AM and stated an investigation related to the resident's injury was not completed because Resident #48 had a history of fondling their (Resident #48's) scrotum which could have caused the injury. Registered Nurse Risk Manager #1 stated that an investigation should have been completed to rule out abuse, neglect, and mistreatment because the injury sustained by the resident was a significant injury of unknown origin. 48827 2) Resident #83 was admitted with diagnoses including Dementia, Type 2 Diabetes Mellitus, and Anxiety. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, which indicated the resident had severely impaired cognition. The Falls Comprehensive Care Plan dated 7/25/2022 and revised on 9/27/2023 documented Resident #82 had a history of falls. The interventions included bed alarm and monitoring for increased confusion, agitation, or behavior changes. A nursing progress note, written by Registered Nurse #3 on 6/22/2024 at 8:05 AM, documented Certified Nurse Assistant #3 reported the resident had a blue/purple discoloration to the right eye. The resident was unable to verbalize or recall what happened. A nursing progress note, written by Registered Nurse Supervisor #4 on 6/22/2024 at 8:30 AM, documented Resident #83 was noted with discoloration to the right eye and right forehead. The resident was unable to describe what happened. Resident #83's family member declined to transfer the resident to the emergency room for a Computerized Tomography (CT) scan. The Accident and Incident report dated 6/22/2024 at 7:30 AM documented that Resident #83 had a discoloration to the right eye and right forehead. The resident was unaware of what happened and the incident was unwitnessed. The written statements obtained from nursing staff during the day shift indicated no one observed a fall or an incident that may have resulted in the identified discoloration. The Accident Investigation Report, Summary of investigation, dated 6/27/2024 documented the nature of the incident: Fall- Discoloration to Right Eye and Forehead. The summary documented there was no sufficient evidence of resident abuse, mistreatment, or neglect. The summary was signed by the facility Administrator and the Director of Nursing Services. Certified Nursing Assistant #3 was interviewed on 7/1/2024 at 2:11 PM and stated they were not assigned to care for Resident #83. They saw Resident #83 in the hallway walking to the dining room on 6/22/2024 during the 7:00 AM to 3:00 PM shift. They noticed the resident had discoloration on the right eye and reported the discoloration to the Nurse. Certified Nursing Assistant #2 was interviewed on 7/1/2024 at 2:19 PM and stated that they were assigned to care for Resident #83 on 6/22/2024 but they did not see Resident #83 until after Certified Nurse Aide #3 reported the bruise on the resident's right eye. Registered Nurse #3 was interviewed on 7/3/2024 at 10:14 AM and stated they observed Resident #83 in bed sleeping when they conducted their morning rounds on 6/22/2024. Registered Nurse #3 stated they were unable to see the resident's face and did not observe the bruise to the resident's right eye. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Supervisor #4 was interviewed on 7/3/2024 at 8:41 AM and stated that when they were notified of the discoloration to the resident's forehead on 6/22/2024, they called the Director of Nursing and investigated the incident. Registered Nurse Supervisor #4 stated they assumed Resident #83 fell . Registered Nurse Supervisor #4 stated they obtained statements from the nursing staff on the day shift. Registered Nurse Supervisor #4 stated the incident occurred on the weekend and they left the report documents in the Risk Manager's mailbox. The Risk Manager was interviewed on 7/3/2024 at 8:52 AM and stated they reviewed Resident #83's incident report on 6/24/2024. The Risk Manager stated they usually do not investigate the previous shift staff and did not know if the previous shift staff should have provided statements related to the resident's injury. The Director of Nursing Services was interviewed on 7/3/2024 at 9:14 AM and stated they were informed of Resident #83's injury on the morning of 6/22/2024. The Director of Nursing Services stated the resident's assigned nursing staff from the previous shifts should have been interviewed to rule out abuse for the injury of unknown origin. 10 NYCCR 415.4(b)(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review, and interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure the comprehensive care plan was reviewed and revised to meet each resident's current needs. This was identified for one (Resident #62) of two residents reviewed for Environment. Specifically, Resident #62, who resided on the second floor of the facility, had behaviors of stuffing the toilet with objects that clogged the toilet resulting in a leaked ceiling in other residents' rooms residing on the first floor. A comprehensive care plan was developed for the resident's behavior in 2014 with interventions to manage the resident's behavior. The resident continued to exhibit the behavior; however, the interventions on the comprehensive care plan remained unchanged since 2014. The finding is: The facility's policy and procedure titled Comprehensive Care Plan, last revised on 11/28/2017, documented each resident will have an individualized interdisciplinary plan of care in place. The Interdisciplinary Team will review and revise the Comprehensive Care Plan on a quarterly basis, with a significant change in condition, on readmission from in-patient hospital stay, and as requested by the Resident/Representative. The Comprehensive Care Plan will be ongoing, constantly evolving, focusing on each individual as a unitary being, constantly changing, and interacting with the environment/energy fields. The Comprehensive Care Plan will address all real/potential problems, needs, strengths, and individual preferences of the resident. Each discipline will be responsible for the initiation and ongoing follow-up for selected care plans as related to their areas of expertise. Resident # 62 was admitted with Diagnoses including Schizophrenia, Mood Disorder, and Anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of two, which indicated the resident had severely impaired cognition. The Minimum Data Set (MDS) assessment documented Resident #62 had behaviors of hallucinations (an experience that involves a perception of something not present), Delusions (misconceptions or beliefs that are firmly held, contrary to reality), and wandering. Resident #62 was continent of bowel and bladder and was not on any toileting program. A physician's order dated 6/18/2024 documented to administer the following: Latuda (anti-psychotic medication) oral tablet 80 milligrams twice a day; Lorazepam (anti-anxiety medication) oral tablet one milligram twice a day; and Depakote Extended Release (mood stabilizer medication) 500 milligrams one tablet at bedtime. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) dated 5/28/2014 and last reviewed on 6/17/2024 for Behavioral Symptoms- Disruptive or Dangerous to self or others as evidenced by: the resident with a history of entering staff offices and grabbing food from garbage/desk; stuffing items in the toilet; wandering into peers' room which may trigger aggression; and stealing food items off peers' tray, food cart and medication cart. Interventions included but were not limited to escorting Resident #62 to a less stimulating environment; involving Resident #62 in behavior programs; monitoring for antecedents (comes before) or early warning signs of problems behavior; and reviewing intensity, duration, frequency, the pattern of behaviors, their development over time, and their effect on resident and others. All the interventions were initiated in 2014 with no new interventions added since 2014. The care plan was evaluated on 6/19/2023, 7/18/2023, 8/21/2023, 9/25/2023, 10/23/2023, 11/20/2023, 12/18/2023, 1/22/2024, 2/19/2024, 4/15/2024, 5/14/2024, and 6/17/2024. Each time the evaluation note documented: Resident displays being preoccupied internally; Resident has a history of stuffing items in the toilet, disrupting immediate living environment. The resident benefits from the structure of the unit. No behaviors noted during the review period. The Maintenance Logbook from 1/4/2024 to 6/5/2024 documented entries that Resident #62's room needed maintenance due to a clogged toilet. The Behavior Follow-Up Assessment Form from 3/14/2024 to 3/19/2024 did not document Resident #62's behavior of stuffing items in the toilet. Certified Nursing Assistant #1 was interviewed on 7/3/2024 at 10:30 AM and stated that Resident #62 often backs up the toilet by stuffing cups, snacks, and other items in the toilet. Certified Nursing Assistant #1 stated they always report the issue to the Nurse for Maintenance to fix the toilet. Registered Nurse #4 was interviewed on 7/3/2024 at 11:00 AM and stated Resident #62 frequently throws different items in the toilet which causes the toilet to clog. Registered Nurse #4 stated the behavior has been ongoing for a long time. Registered Nurse #4 stated the Certified Nursing Assistant supervised Resident #62's continence needs, but most of the time, Resident #62 goes to the bathroom independently. Registered Nurse #4 stated they usually call the maintenance staff to unclog the toilet. The Maintenance Director was interviewed on 7/3/2024 at 11:30 AM and stated they had fixed Resident #62's toilet numerous times. Once the toilet is clogged, it causes a backflow, causing a leak in another resident's bathroom that is located below Resident #62's bathroom. The Maintenance Director stated they did not know what else to do because of Resident #62's continuing behavior of stuffing items in the toilet. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Behavior Program Director was interviewed on 7/3/2024 at 1:00 PM and stated they primarily worked on the Behavior Unit where Resident #62 resides. The Behavior Program Director stated updating Resident #62 care plan is their responsibility. The Behavior Program Director stated that Resident #62's care plan interventions have not been revised since 2014 because the behavior has been the same for a long time. The Behavior Program Director stated as far as the Behavior Department, Resident #62's behavior of stuffing items in the toilet had stopped. The Behavior Program Director stated that the Maintenance and Nursing department did not tell them that Resident #62 had been stuffing items in the toilet, otherwise the behavior team would have completed a Behavior Follow Up Assessment Form to trigger a new intervention in the care plan. The Behavior Program Director stated they had written the same evaluation on the care plan monthly for the past year because the resident's behaviors were the same and there were no reports from other disciplines that Resident #62 had been stuffing items in the toilet. The Behavior Supervisor was interviewed on 7/5/2024 at 12:09 PM and stated they had written the same evaluation note on the care plan for Resident #62 because there were no new behaviors reported. The Behavior Supervisor stated they did not know that Resident #62 was stuffing items in the toilet and clogging the toilet and if they knew, they would have triggered a behavior follow-up and added new interventions to the care plan. The Director of Nursing Services was interviewed on 7/5/2024 at 12:36 PM and stated the care plan for Resident #62 should have been updated for any changes, especially with new behaviors, but the resident's behaviors were not new. The Director of Nursing Services stated the intervention should have been evaluated for effectiveness and if ineffective, then a new care plan intervention should have been initiated to address the resident's needs. 415.11(c)(2) (i-iii)

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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** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for two (Resident # 107 and Resident #138) of five residents reviewed for Pressure Ulcers. Specifically, Resident #107 and Resident #138 had a physician's order for an alternating pressure relief air mattress. During multiple observations, the adjustable weight setting on the air mattress pump was not accurately set according to each resident's weight. The findings are: The facility's Pressure Ulcers policy and procedure last revised on 5/21/2019 documented that residents who have pressure ulcers receive the necessary treatment to promote healing, prevent infection, and prevent new ulcers from developing. Residents will be assessed for pressure ulcer risk factors upon admission, re-admission, quarterly, and with change in condition. It is the Nurse's responsibility to oversee the Pressure Ulcer program which includes ensuring an appropriate Plan of Care is implemented and carried through, conducting weekly pressure ulcer rounds with the Physician, and completing the pressure ulcer progress assessment form. The Operation Manual for the Alternating Pressure and Low Air Loss Mattress System documented the adjustable patient weight settings allow for optimal immersion, patient comfort, and compliance. The weight capacity was documented to be 350 pounds. 1) Resident #107 was admitted with diagnoses including Spinal Stenosis, Pressure Ulcer of the Sacral Region, and Respiratory Failure. The Admission Minimum Data Set assessment dated [DATE] documented no Brief Interview for Mental Status score due to Resident #107's severe cognitive impairment. The Minimum Data Set assessment documented Resident #107 was at risk for developing a pressure ulcer and had one Stage 4 (defined as full-thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on the sacrum. A Comprehensive Care Plan for Pressure Ulcer dated 4/11/2024 documented interventions included heel and elbow protectors as needed, and the use of an air mattress. A physician's order dated 4/11/2024 documented the use of an alternating pressure relief air mattress. A physician's order dated 6/5/2024 documented to apply Santyl (medication that removes damaged tissue from the area) ointment to the sacral ulcer; lightly pack the wound with Calcium Alginate (medication that absorbs excess moisture and promotes healing); and then cover with silicone border gauze twice a day. A review of the electronic medical record indicated that Resident #107's most recent weight was 156 pounds on 6/13/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound Care Progress Note dated 6/21/22024 documented the resident's sacral wound measured 5.5 centimeters in length 3.0 centimeters in width and 0.5 centimeters in depth. The wound bed was noted with 100 percent granulation (new tissues and blood vessels) tissue and the surrounding skin was intact. There was a moderate amount of serous (pale, yellow watery fluid) drainage with no odor. The progress note documented multiple other wounds with measurements and treatment recommendations including a left hip Deep Tissue Injury, a left elbow ulcer, a right lateral ankle wound, and a right inner thigh wound. Resident # 107 was observed lying in bed on 6/27/2024 at 12:15 PM. The alternating air mattress pump was set at 350 pounds. Resident #107 was observed in lying bed on 6/28/2024 at 9:00 AM. The alternating air mattress pump was set at 350 pounds. Resident # 107 was observed in lying bed on 7/1/2024 at 11:55 AM. The alternating air mattress pump was set at 350 pounds. Registered Nurse #4, the Unit Manager, was interviewed on 7/1/2024 at 11:40 AM and stated that Licensed Nurses are responsible for monitoring that the weight setting on the air mattress is set based on the resident's actual weight. Registered Nurse #4 stated there was a physician's order for the use of an alternating air mattress; however, there was no order to monitor the air mattress settings and therefore the monitoring was not being completed and documented every shift. Certified Nursing Assistant # 5 was interviewed on 7/1/2024 at 11:20 AM and stated they were responsible for checking the resident's alternating air mattress was appropriately inflated. Certified Nursing Assistant #5 stated they do not touch the alternating air mattress pump nor change the settings on the air mattress. The Wound Care Manager was interviewed on 7/2/2024 at 9:15 AM and stated the alternating air mattress weight setting should correspond with the resident's weight. All staff are responsible for monitoring the air mattress. The Wound Care Manager stated Resident #107 weighed 156 pounds and they were not sure why the alternating air mattress weight setting was set at 350 pounds. Physician #1, the Wound Care Physician, was interviewed on 7/2/2024 at 1:29 PM and stated it was up to the facility to ensure that the air mattress setting was properly monitored. Physician #1 stated for optimal wound healing the alternating air mattress weight setting should be calibrated to match the resident's actual weight. The Director of Nursing Services was interviewed on 7/2/2024 at 2:12 PM and stated the nursing staff should have monitored the alternating air mattress weight setting every shift. Monitoring the air mattress can be documented every shift by the nurses in the treatment administration record or the medication administration record. 34798 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #138 was admitted with diagnoses including Alzheimer's Disease, Seizure Disorder, and Aphasia. The 6/24/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 1, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented that the resident had one Stage 4 pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle) with an intervention for a pressure-reducing device for the bed. The resident's documented weight was 139 pounds. An actual Pressure Ulcer Comprehensive Care Plan, effective 2/15/2024 and last updated on 6/21/2024, documented the resident had a Stage 4 pressure ulcer to the sacral area. The intervention included the use of an alternating air mattress for Resident #138. A physician's order as of 7/2/2024 documented to cleanse the resident's sacral ulcer with normal saline, apply Calcium Alginate (an absorptive wound dressing) to the wound bed, and cover with silicone-bordered gauze twice a day. A wound assessment completed by Registered Nurse #1, the wound care nurse, dated 6/21/2024 documented the resident had a Stage 4 sacral ulcer measuring 1.7 centimeters in length, 1.2 centimeters in width, and 1.0 centimeters in depth with tunneling/undermining (occurs when significant erosion occurs underneath the outwardly visible wound margins resulting in more extensive damage beneath the skin surface; the clock scale provides the basic location of the undermining) 1.5 centimeters at 5-12 o'clock. The wound care recommendations included providing a special alternating air mattress or offloading devices if indicated. Resident #138 was observed in their room sitting in a Geri chair (a chair used for residents who have difficulty sitting upright in a conventional wheelchair) adjacent to their bed on 6/27/2024 at 2:03 PM. The resident's bed had an alternating air mattress with the weight setting set at 350 pounds. Resident #138 was observed in bed on 6/28/2024 at 8:05 AM. The alternating air mattress weight setting was set at 350 pounds. Registered Nurse #4, who is the supervisor, was interviewed on 6/28/2024 immediately after the observation. Registered Nurse #4 stated the resident did not weigh 350 pounds and the setting on the mattress should be set to the resident's weight of 139 pounds. Registered Nurse #4 adjusted the alternating air mattress setting to 139 pounds. Registered Nurse #1, the wound care nurse, was interviewed on 7/2/2024 at 9:00 AM and stated it is the facility's policy that residents with Stage 3 and 4 sacral pressure ulcers are provided an alternating air mattress. The alternating air mattress weight setting is based on the resident's weight. The nurses are supposed to check the alternating air mattress weight setting; however, there is no documentation to confirm. The certified nursing assistants are supposed to check the alternating air mattress to make sure the mattress is not deflated, but they do not adjust the weight setting. Certified Nursing Assistant #1 was interviewed on 7/2/2024 at 11:32 AM and stated the Certified Nursing Assistants do not adjust the alternating air mattress weight setting; they just check the alternating air mattress to make sure the mattress is not deflated and let the nurse know if there is a problem. Certified Nursing Assistant #1 stated they do not check the weight setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #138's wound care treatment was observed on 7/2/2024 at 11:36 AM. Registered Nurse #2 performed the wound care treatment and was assisted by Certified Nursing Assistant #7. The alternating air mattress weight setting was set at 150 pounds. Wound Care Physician #1 was interviewed on 7/2/2024 at 1:29 PM and stated they recommended the use of an alternating air mattress for Resident # 138, but it was up to the facility to ensure that the alternating air mattress was monitored properly. Wound Care Physician #1 expected the facility to follow the weight of the resident and calibrate the alternating air mattress accordingly. Wound Care Physician #1 stated proper calibration of the alternating air mattress was important to ensure effective wound healing. The Director of Nursing Services was interviewed on 7/2/2024 at 1:59 PM and stated the facility did not have a plan in place for monitoring the alternating air mattress weight setting. The nurses should monitor the air mattress setting, including the weight setting, every shift. The Certified Nursing Assistants should notify the nurse when they notice that the mattress is overinflated or underinflated. 10 NYCRR 415.12(c)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review and interviews conducted during a Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice. This was identified for one (Resident #113) of two residents reviewed for Respiratory Care. Specifically, Resident #113 had a physician's order to receive 3 liters of oxygen per minute every shift. The resident was observed receiving 4. 5 liters of oxygen per minute on 6/27/20224 and 6/28/2024 and 5 liters of oxygen per minute on 7/1/2024. The finding is: The facility's policy and procedure titled Oxygen Concentrator last revised in March 2017, documented that while delivering oxygen via an oxygen concentrator, the flow meter knob is to be adjusted to the ordered flow rate. All precautions for traditional oxygen therapy will be adhered to for oxygen administration. The facility's policy and procedure titled General Oxygen Administration last revised in February 2017, documented to administer oxygen as per the physician's order. Assess the resident for signs of adverse reactions to oxygen therapy (hypoventilation and bradypnea-abnormally slow breathing), and therapeutic response to oxygen. Resident #113 was admitted with diagnoses including Heart Failure, Morbid Obesity, and Atrial Fibrillation. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The Minimum Data Set further documented the resident did not receive oxygen therapy. A physician's order dated 5/29/2024 documented to administer oxygen at 3 liters per minute via a nasal cannula every shift. No diagnosis was indicated for the use of oxygen therapy. The Comprehensive Care Plan for Alteration in Respiratory Status dated 5/29/2023 revised on 5/30/2024, documented interventions including administering oxygen at 3 liters per minute. Resident # 113 was observed sitting in their wheelchair near their bed on 6/27/2024 at 11:16 AM. Resident #113 was using a nasal cannula that was attached to an oxygen concentrator. The oxygen concentrator was out of Resident #113's reach. The display window on the oxygen concentrator indicated Resident # 113 was receiving 4.5 liters of oxygen per minute. Resident #113 was observed in bed on 6/28/2024 at 9:20 AM. Resident #113 was using a nasal cannula that was attached to an oxygen concentrator, which was placed at the end of the resident's bed. The oxygen concentrator was out of Resident #113's reach. The display window on the oxygen concentrator indicated Resident # 113 was receiving 4.5 liters of oxygen per minute. Resident #113 declined to be interviewed at this time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #113 was observed sitting in a wheelchair by their bed on 7/1/2024 at 11:52 AM. Resident #113 was using a nasal cannula that was attached to an oxygen concentrator. The display window on the oxygen concentrator indicated the resident was receiving oxygen at 5 liters per minute. The oxygen concentrator was out of Resident #113's reach. Resident #113 stated they were not able to change the setting on the concentrator and the oxygen therapy made no difference to their breathing. The display window on the oxygen concentrator was again observed with Licensed Practical Nurse #1 on 7/1/2024 at 11:58 AM. The display window on the oxygen concentrator indicated the resident was receiving oxygen at 5 liters per minute. Licensed Practical Nurse #1 adjusted the oxygen to 3 liters per minute and stated Resident #113 was not supposed to be receiving oxygen at 5 liters. Licensed Practical Nurse #1 was interviewed immediately after the observation on 7/1/2024 at 11:58 PM and stated any licensed nursing staff could check Resident #113's oxygen at the start of the shift. Licensed Practical Nurse #1 stated they could not recall if they had checked the resident's oxygen concentrator today, 7/1/2024. Licensed Practical Nurse #1 stated that Resident #113 could not reach the oxygen concentrator to change the oxygen setting. Licensed Practical Nurse #1 stated this was not the first time they had observed Resident #113's oxygen set at a higher rate than ordered. Licensed Practical Nurse #1 stated they did not know why the oxygen was set high on those occasions. Licensed Practical Nurse #1 stated the resident should receive oxygen as ordered by the Physician. The Treatment Administration Record from 5/1/2024 to 7/1/2024 was reviewed and indicated Resident #113 was receiving oxygen at 3 liters per minute every shift including on 6/27/2024, 6/28/2024, and 7/1/2024. Licensed Practical Nurse #2, who was Resident #113's regularly assigned medication nurse, was interviewed on 7/3/2024 at 1:30 PM. Licensed Practical Nurse #2 stated licensed nurses are responsible for ensuring that the oxygen is administered as per the physician's orders. Physician #2, the attending Physician for Resident #113, was interviewed on 7/2/2024 at 2:55 PM. Physician #2 stated the resident should receive oxygen at 3 liters per minute as per the written order. The Director of Nursing Services was interviewed on 7/8/2024 at 10:09 AM and stated they expected the licensed nurses to ensure that the residents receive oxygen therapy as per the physician's orders. 10 NYCRR 415.12(k)(6)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review and interviews conducted during a Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure the medical care of each resident is supervised by a Physician. This was identified for one (Resident #113) of two residents reviewed for Respiratory Care. Specifically, Resident #113 had a physician's order for supplemental oxygen therapy at 3 liters per minute every shift; there was no rationale documented for the use of supplemental oxygen. Additionally, the resident expressed that the oxygen therapy has not been effective. There was no documented evidence in the resident's medical record that the Physician monitored and evaluated the resident's oxygen therapy needs until after the Surveyor brought the concern to the facility's attention on 7/2/2024. The finding is: The facility's policy and procedure titled Clinical Operations dated April 2019 documented that the Physician will participate in the resident's assessment and plan of care, monitor changes in their clinical condition, provide consultation or treatment, and oversee the plan of care of the resident. The Physician will perform pertinent and timely medical assessments, prescribe an appropriate medical plan of care, and provide adequate information regarding the resident's condition and medical needs. Resident #113 was admitted with diagnoses including Heart Failure, Morbid Obesity, and Atrial Fibrillation. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The Minimum Data Set documented the resident did not receive oxygen therapy. A physician's order dated 5/29/2024 documented to administer oxygen at 3 liters per minute via a nasal cannula every shift. No diagnosis was indicated for the use of oxygen. The Comprehensive Care Plan for Alteration in Respiratory Status dated 5/29/2023 was revised on 5/30/2024 to document an intervention for oxygen at 3 liters per minute. All progress notes were reviewed from 5/1/2024 to 5/29/2024. There was no documented evidence of any report, assessment, or evaluation related to Resident #113's change in respiratory status or reason for starting oxygen treatment on 5/29/2024. A Physician's progress note dated 5/30/2024, written by Physician #2, documented that Resident #113 was comfortable at examination, lung clear to auscultation (Lung sounds are normal), and cardiovascular S1 S2 (normal rate and rhythm of the heart). The progress note did not include an assessment or plan for oxygen therapy. The Monthly Physician Assessment and Plan of Care dated 6/6/2024 and 7/2/2024 written by Physician #2 did not include an assessment of the resident's lung and did not document the use of oxygen therapy. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #113 was observed and interviewed on 7/1/2024 at 11:52 AM. The resident was sitting in their wheelchair by their bed and was using a nasal cannula that was attached to an oxygen concentrator. Resident #113 stated that the oxygen therapy made no difference to their breathing, there's got to be something better. Resident #113 stated they had asked but did not receive any feedback from Nurses and doctors on weaning off their oxygen. Licensed Practical Nurse #1, who was the unit manager where Resident #113 resided, was interviewed on 7/1/24 at 11:58 AM. Licensed Practical Nurse #1 stated they believed Resident #113 was using oxygen because the resident had Chronic Heart Failure. Licensed Practical Nurse #1 stated they were not aware of any plan to re-assess and monitor whether Resident #113's continued use of oxygen is necessary. Resident #113's attending physician, Physician #2, was interviewed on 7/2/2024 at 2:55 PM and stated Resident #113 did not experience changes in respiratory status when oxygen therapy was initiated on 5/29/2024. Physician #2 stated that they believed they ordered the oxygen to encourage the resident to comply with care such as taking a shower as the resident was afraid of having a low oxygen level when they used the shower. Physician #2 stated they did not document a rationale for the oxygen therapy and parameters for monitoring the resident's oxygen saturation levels and should have. Physician #2 stated that the current oxygen order for Resident #113 was wrong as written. The order should have been included to check Resident #113's oxygen saturation every shift and provide oxygen therapy as needed if the oxygen saturation level was below 92%. Physician #2 stated that when a resident is on oxygen therapy, their oxygen saturation must be measured to monitor progress and to determine if a higher level of respiratory care is needed. The Medical Director was interviewed on 7/3/2024 at 12:28 PM and stated they expected the attending Physician to monitor the resident's condition regularly and adjust the course of treatment and interventions as appropriate. The Medical Director stated that Physician #2 should have documented their rationale when oxygen therapy was ordered and included the parameters. The Medical Director stated Resident #113 has been on oxygen therapy for five weeks and the resident cannot be on continuous oxygen forever. The Medical Director stated Physician #2 should have monitored the resident's respiratory status and re-evaluated the resident to determine if oxygen remains an appropriate intervention. 10 NYCRR 415.15(b)(1)(i)(ii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34798 Based on record review and interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for five of the five units reviewed for the Sufficient Nursing Staffing task. Specifically, 1) a review of the Payroll-Based Journal (PBJ) Staffing Data Report Quarter 1, 2024 indicated excessively low weekend staffing and 2) a review of the daily staffing sheets revealed that the facility did not provide sufficient numbers of Certified Nursing Assistants as indicated in the facility assessment. The finding is: The facility's Policy and Procedure on Staffing last reviewed 7/2024, documented the facility maintains adequate staffing on each shift to ensure that our residents' needs and services are met. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined in the resident's comprehensive care plan. The Registered Nurse Supervisor on duty for each shift will update the daily staffing census sheet. Our facility furnishes information from payroll records setting forth the average numbers and types of personnel on each shift to the New York State Department of Health. The Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter One 2024 (October 1-December 31) documented the facility triggered for the metric of excessively low weekend staffing. The Facility Assessment Tool dated 6/26/2024 documented the average daily census was 170-182 residents. The assessment documented the facility required 19 licensed nurses to provide care on a daily basis and 44 Certified Nursing Assistants to provide care on a daily basis. A review of weekend staffing sheets from 1/7/2024 to 3/17/2024 revealed there were less than 44 Certified Nursing Assistants available to care for residents on a daily basis. The Staffing Coordinator was interviewed on 6/28/2024 at 12:13 PM and stated the facility was having problems with staffing on the weekends, mainly on Sundays, because many of the full-time Certified Nursing Assistants have resigned. The Staffing Coordinator stated the 7:00 AM to 3:00 PM shift requires 19 Certified Nursing Assistants in total, the 3:00 PM to 11:00 PM shift requires 13 Certified Nursing Assistants, and the 11:00 PM to 7:00 AM shift requires 10 Certified Nursing Assistants based on the Daily Staffing Schedule sheets that they use to fill all of the Certified Nursing Assistant slots. The Staffing Coordinator was not sure why the Facility Assessment documented that 44 Certified Nursing Assistants were required on a daily basis because the Daily Staffing Schedule indicated a need for 42 Certified Nursing Assistants daily. The Staffing Coordinator reviewed the Daily Staffing Schedule sheets from 1/1/2024 to 3/31/2024 and stated that short staffing for Certified Nurse Assistants is an ongoing issue every other weekend. A review of weekend staffing from 1/1/2024 to 3/31/2024 revealed insufficient staffing. Examples included but were not limited to the following: (continued on next page)

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	335024	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Terrace Care Center	640 West Broadway Long Beach, NY 11561

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 1/7/2024, during the 7:00 AM to 3:00 PM shift, there were 11 Certified Nursing Assistants on duty. Based on the Staffing Coordinator's Daily Staffing Schedule sheet there should be 19 Certified Nursing Assistants. There were 32 total Certified Nursing Assistants for 1/7/2024 compared to the 44 as indicated in the facility assessment. -On 1/21/2024, during the 7:00 AM to 3:00 PM shift, there were 13 Certified Nursing Assistants on duty. Based on the Staffing Coordinator's Daily Staffing Schedule sheet there should be 19 Certified Nursing Assistants. There were 31 total Certified Nursing Assistants for 1/21/2024 compared to the 44 as indicated in the facility assessment. -On 2/4/2024, during the 7:00 AM to 3:00 PM shift, there were 17 Certified Nursing Assistants on duty. Based on the Staffing Coordinator's Daily Staffing Schedule there should be 19 Certified Nursing Assistants. There were 38 total Certified Nursing Assistants for 2/4/2024 compared to the 44 as indicated in the facility assessment. -On 2/18/2024, during the 7:00 AM to 3:00 PM shift, there were 14 Certified Nursing Assistants on duty. Based on the Staffing Coordinator's Daily Staffing Schedule there should be 19 Certified Nursing Assistants. There were 35 total Certified Nursing Assistants for 2/18/2024 compared to the 44 as indicated in the facility assessment. -On 3/3/2024 and 3/31/2024, during the 7:00 AM to 3:00 PM shift, there were 15 Certified Nursing Assistants. Based on the Staffing Coordinator's Daily Staffing Schedule there should be 19 Certified Nursing Assistants. There were 40 total Certified Nursing Assistants for 3/3/2024 compared to the 44 as indicated in the facility assessment. -On 3/17/2024, during the 7:00 AM to 3:00 PM shift, there were 16 Certified Nursing Assistants. Based on the Staffing Coordinator's Daily Staffing Schedule there should be 19 Certified Nursing Assistants. There were 38 total Certified Nursing Assistants for 3/17/2024 compared to the 44 as indicated in the facility assessment. The Director of Nursing Services and the Staffing Coordinator were interviewed concurrently on 7/3/2024 at 9:35 AM. The Staffing Coordinator stated the facility has been short-staffed with Certified Nursing Assistants on the weekends for a long time because there is no public transportation to the facility on the weekends. The Director of Nursing Services stated there is a high turnover of Certified Nursing Assistants and the facility has difficulty retaining Certified Nursing Assistants. The Director of Nursing Services stated the facility utilizes a staffing agency; however, the agency staff cannot be mandated to work on the weekends. The Director of Nursing Services stated that full-time employees are required to work every other weekend as per their union contract. The Director of Nursing Services stated they know that the insufficient staffing issue on the weekends occurs on alternate weekends; however, they have not attempted to adjust the staffing schedules. The Director of Nursing Services stated they had been unable to come up with a solution to address the facility's insufficient staffing issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on 7/8/2024 at 10:58 AM and stated they were aware of the insufficient staffing issue at the facility, especially on the weekends. The Administrator stated public transportation to the facility is limited and the full-time staff wants higher wages. The Administrator stated they have been thinking about doing a job fair but have not done one yet since becoming Administrator 13 months ago. The Administrator stated they assumed the Director of Nursing Services and the Staffing Coordinator were staggering the schedules to fill the weekend staffing needs. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observations, record review, and interviews during the Recertification Survey initiated on 6/27/2024 and completed on 7/8/2024, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles. This was identified on two (Unit 2 East and Unit 2 West) of three units reviewed during the Medication Storage Task. Specifically, 1) a used vial (bottle) of insulin for Resident #86 was observed in the medication refrigerator, on Unit 2 East on 7/2/2024, with an open date of 5/29/2024; 2) two opened bottles of Latanoprost Ophthalmic Solution for Resident #76 and Resident #109 were observed in the medication cart on Unit 2 [NAME] on 7/2/2024 without a date that indicated when the eye drop bottles were opened; and 3) a used vial of insulin for Resident #55 was observed in the medication refrigerator, on Unit 2 [NAME] on 7/2/2024, with an opened date of 5/27/2024. The findings are: The facility policy titled Medication: Storage and Handling dated 2/23/2017 and revised on 7/5/2024 documented that the unit nurse will ensure that all resident medications are to be properly labeled, restored, and locked securely in the medication room. Medications and other solutions past their noted expiration date are to be removed from usage and returned to the pharmacy to ensure the desired effect when utilized. No discontinued, outdated, or deteriorated drugs or biologicals are to be used for resident care. All eye drops and insulins for resident care will be discarded 28 days from the opening date. 1) Resident #86 was admitted with diagnoses including Type 2 Diabetes Mellitus and End Stage Renal Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident's cognition was intact. The Minimum Data Set assessment documented the resident was receiving insulin injections during the assessment period. A physician's order for Resident #86 dated 3/8/2024 and renewed on 6/28/2024 documented to administer Humalog insulin (fast-acting insulin) Subcutaneous Solution 100 units per milliliter three times daily before meals for Type 2 Diabetes Mellitus according to blood sugar readings as follows: 151 milligrams per deciliter-200 milligram per deciliter=2 units, 201 milligrams per deciliter-250 milligram per deciliter=4 units, 251 milligrams per deciliter-300 milligram per deciliter=6 units, 301 milligrams per deciliter-350 milligrams per deciliter=8 units, 351 milligrams per deciliter-400 milligrams per deciliter=10 units, and notify the Physician for a blood sugar reading below 60 milligram per deciliter or over 400 milligrams per deciliter. An observation of the Medication Storage was conducted with Licensed Practical Nurse #5 on Unit 2 East on 7/2/2024 at 10:55 AM. A used vial of Humalog insulin solution for Resident #86 was observed in the medication refrigerator. The insulin vial had an open date of 5/29/2024 documented on the vial indicating the vial had been opened for more than 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #5, the medication nurse for Unit 2 East, was interviewed on 7/2/2023 at 1:49 PM. Licensed Practical Nurse #5 stated they thought the Humalog insulin vial for Resident #86 that was in the medication refrigerator was new and overlooked the date documented on the insulin vial. Licensed Practical Nurse #5 further stated the vial of Humalog insulin solution should have been removed from the medication refrigerator and discarded after 28 days the insulin vial was opened. Licensed Practical Nurse #4, Nurse Manager for Unit 2 East, was interviewed on 7/3/2024 at 9:47 AM and stated that the insulin vial should have been discarded after 28 days from when it was first opened. 2) Resident #76 was admitted with diagnoses including Glaucoma (an eye condition that can cause vision loss) and Type 2 Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, indicating the resident had severe cognitive impairment. A Physician's Order for Resident #76 dated 7/12/2023 and renewed on 6/11/2024 documented to administer one drop of Latanoprost Ophthalmic Solution 0.005 percent into the left eye at bedtime for Glaucoma. Resident #109 was admitted with diagnoses including Bilateral (both eyes) Pre-Glaucoma (a condition in which the pressure in the eye is higher than normal) and Hypertension. The Significant Change in Status Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 7, indicating the resident had severe cognitive impairment. A Physician's order for Resident #109 dated 4/26/2024 and renewed on 7/5/2024 documented to administer one drop of Latanoprost Ophthalmic Solution 0.005 percent to both eyes at bedtime for Bilateral Pre-Glaucoma. An observation of the Medication Storage was conducted with Licensed Practical Nurse #3 on Unit 2 [NAME] on 7/2/2024 at 11:31 AM. Two used bottles of Latanoprost Ophthalmic solution 0.005 percent for Resident #76 and Resident #109 were observed in the medication cart. There was no date documented on the bottles to indicate when they were first opened. 3) Resident #55 was admitted with diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy (a type of nerve damage) and Hypertension. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident was receiving insulin injections during the assessment period. A Physician's Order for Resident #55 dated 6/6/2024 and renewed on 6/21/2024 documented to administer 35 units of Insulin Glargine-yfgn (a long-acting insulin) 100 unit per milliliter subcutaneous Solution daily for Type 2 Diabetes Mellitus with Diabetic Neuropathy. An observation of the Medication Storage was conducted with Licensed Practical Nurse #3 on Unit 2 [NAME] on 7/2/2024 at 11:53 AM. A used vial of Insulin Glargine-fygn solution was observed for Resident #55 in the medication refrigerator. The insulin vial had an open date of 5/27/2024 documented on the vial indicating the vial had been opened for more than 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #3, the medication nurse for Unit 2 West, was interviewed on 7/2/2024 at 2:33 PM. Licensed Practical Nurse #3 stated the Ophthalmic Solution bottles should be discarded 30 days from opening. Licensed Practical Nurse #3 stated the bottles of Latanoprost Ophthalmic Solution for Resident # 76 and Resident #109 should have been dated when they were first opened so that the unit nurses could determine when to discard the medication. Licensed Practical Nurse #3 stated the vial of insulin Glargine solution should be discarded 28 days after opening. Licensed Practical Nurse #1, the Nurse Manager for Unit 2 West, was interviewed on 7/3/2024 at 9:43 AM and stated the unit nurses were responsible for proper labeling and storage of medications on the unit. Licensed Practical Nurse #1 stated the bottles of Latanoprost Ophthalmic solution for Resident #76 and Resident #109 should have been dated when first opened by nursing staff. The used vial of insulin Glargine for Resident #55 should have been discarded 28 days after the vial was first opened. The Pharmacist was interviewed on 7/5/2024 at 10:23 AM and stated Humalog insulin and Glargine insulin should be discarded 28 days after opening. The potency of the insulin decreases and the medications may become less effective after 28 days of opening. The Pharmacist stated Latanoprost 0.005 percent Ophthalmic solution should be discarded six weeks after opening because the medication becomes less effective. The Director of Nursing Services was interviewed on 7/5/2024 at 12:35 PM and stated all ophthalmic solutions and insulin solutions should be discarded 28 days after they were opened. All unit nurses should ensure proper labeling and storage of medications. The Director of Nursing Services further stated the bottles of Latanoprost Ophthalmic Solution for Resident #76 and Resident #109 should have been dated when the bottle was first opened. The insulin vials for Resident #86 and Resident #55 should have been discarded 28 days after the vials were first opened. 10 NYCRR 415.18 (d);10 NYCRR 415.18(e)(1-4)