STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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** 28670 Based on record review and staff interviews during the Recertification Survey and Abbreviated Survey (NY 00323920) initiated on 12/8/2023 and completed on 12/14/2023 the facility did not ensure that all injuries of unknown source were reported immediately, but not later than 2 hours if there are serious bodily injury, or not later than 24 hours if there are no serious bodily injuries. Specifically, on 7/21/2023 Resident #274 was identified with an injury of unknown origin. There was no documented evidence that the injury was reported to the New York State Department of Health (NYSDOH) as required. The finding is: The facility's Abuse Prevention policy and procedure effective February 2023 documented that all alleged violations must be immediately reported to the Administrator, state agency, and any other required law enforcement agencies within the specified time frame. The policy documented that all alleged violations of abuse, neglect, exploitation, or mistreatment, including injury of unknown source and misappropriation of resident property should be reported to the facility Administrator and to the State Agency. All alleged violations are reported immediately but no later than two hours if the alleged violation involves abuse or result in serious bodily injury and within 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. The facility's Accident Incident Report Investigation and Intervention policy and procedure dated March 9/2023 documented in the event a resident was involved in an accident or incident in which it is reasonable to assume, based on the facts that negligence is involved, the occurrence shall be reported to the New York State Health Department. Resident #274 was admitted with diagnoses that include Hypertension, Non-Alzheimer's Dementia, and Basal Cell Carcinoma of the Skin. An Annual Minimum Data Set (MDS) assessment dated [DATE] documented the resident's Brief Interview for Mental Status (BIMS) score was 4, which indicated the resident's cognition was severely impaired. The resident had no behavioral symptoms and required extensive assistance of one staff member for bed mobility, locomotion on the unit, dressing, toileting, personal hygiene. The resident required extensive assistance of two staff members for transfers. A Progress Note dated 7/21/2023 at 12:00 PM documented Resident #274 was observed with an unwitnessed bruising to the left eyebrow area. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Accident Incident (A/I) Report dated 7/21/2023 at 12:00 PM documented the resident was observed with bruising to the left eyebrow; however, the resident was unable to state how they sustained the bruising. The A/I documented the resident had a diagnosis of Dementia. A Comprehensive Care Plan (CCP) dated 7/25/2023 for Skin Integrity: Ecchymosis (bruise) documented the resident had an ecchymosis to the left eyebrow. Interventions included to assess the resident's skin every shift; monitor for pain, discomfort, medicate as needed; monitor the healing process and regularly check efficacy of treatment. Safety padding placed on upper bed parameters. Certified Nursing Assistant (CNA) #6 was interviewed on 12/13/2023 at 9:30 AM and stated that they were the regularly assigned CNA for Resident #274; however, on 7/21/2023 they were not working at the facility. CNA #6 stated that the resident was cooperative with care and did not lash out at staff during care. CNA #7, who cared for the resident on 7/21/2023 during the 7:00 AM - 3:00 PM shift, was interviewed on 12/13/2023 at 10:26 AM and stated that on 7/21/2023 at 8:00 AM they went to the resident's room to hand out the breakfast tray and that at the same time the medication nurse entered the resident's room to administer medication to the resident. CNA #7 stated that they set up the tray for the resident and at around 8:30 AM they collected the resident's tray, lowered the resident's bed, and placed the floor mat by the bed side then left the room. CNA #7 stated at that time they did not observe any discoloration to the resident's face. CNA #7 stated that at 11:30 AM they observed that the resident had a bruise to the left side of the face near the eye. CNA #7 stated they reported the bruise to the Licensed Practical Nurse (LPN #7). LPN #7, who was on duty on 7/21/2023, was interviewed on 12/14/2023 at 1:13 PM. LPN #7 stated they could not recall the events of 7/21/23 on their shift. The Director of Nursing Service (DNS) was interviewed on 12/14/2023 at 3:04 PM and stated that the RN on the shift was responsible for initiating the investigation. The DNS stated that statements from all staff involved would be obtained. The DNS stated if the resident's roommates at the time of the incident were interviewable, statements should have been obtained from the residents and that the statements should be included in the investigation. The DNS stated that the Administrator determines when an incident should to be reported to the Department of Health. The DNS stated they would have to review the facility policy on reporting to determine if the bruise should have been reported to the NYSDOH. The Assistant Director of Nursing Services (ADNS) was interviewed on 12/14/2023 at 4:02 PM. The ADNS stated that when an injury of unknown origin is reported to them, they assess the resident's area to determine what might have occurred. The ADNS stated that while the resident was in bed, they did a reenactment with the resident to determine what might have occurred. The ADNS stated based on their reenactment they did not report the injury to the NYSDOH as they felt the injury did not occur as a result of abuse. The ADNS stated they did consider the injury as unknown origin; however, based on their investigation felt the resident probably sustained injury during care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 12/14/2023 at 4:18 PM. The Administrator stated that the person that summarized the investigation and themselves determine when to report an incident to the NYSDOH. The Administrator stated that although Resident #274's injuries are of unknown origin, they did not report the injury to the NYSDOH because not every unwitnessed injury is reportable. The Administrator stated that based on interviews with staff, the assessment of the resident area, and no reported unusual events, they concluded that the injury was not a reportable event. 10 NYRR 415.4(b)(2)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and interviews during the Recertification Survey initiated on 12/10/2023 and completed on 12/14/2023, the facility did not ensure that the Office of the Long-Term Care Ombudsman was notified of each resident's transfer or discharge to the hospital. This was identified for one (Resident #75) of two residents reviewed for hospitalization . Specifically, Resident #75 was discharged to the hospital on 10/21/2023 and no notification of the discharge was sent to the Office of the Long-Term Care Ombudsman. The finding is: Resident #75 was admitted to the facility with diagnoses including Parkinson's Disease with Dyskinesia and Alzheimer's Disease. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had severely impaired cognitive skills for daily decision making with long and short term memory problems. The Nursing Progress Note dated 10/21/2023 at 1:58 PM documented the resident was observed breathing abnormally. Medical group was called and spoke to on call person who ordered Metoprolol (a medication that affects the heart and circulation) 25 milligrams (mg) 1 dose, Complete Blood Count (CBC), Basal Metabolic Panel (BMP), and Electrocardiogram (EKG). The Nursing Progress Note dated 10/21/2023 at 2:26 PM documented the resident was reassessed and the medical group called. The Physician Assistant (PA) ordered hydration, 0.9% normal saline intravenously at 70 milliliters (ml) per hour. The Nursing Progress Note dated 10/21/2023 at 2:56 PM documented that the resident was being transferred out for evaluation. The Registered Nurse (RN) Supervisor Progress Note dated 10/21/2023 at 4:08 PM documented that the resident was transferred to the hospital at approximately 3:30 PM for further evaluation. The RN Supervisor Progress Note dated 10/21/2023 at 9:49 PM documented that the resident was admitted with a diagnosis of Severe Sepsis. The Social Services Progress Note dated 10/30/2023 7:00 PM documented that the resident was admitted to the hospital on 10/21/2023 with a diagnosis of Severe Sepsis. The resident's belongings were packed up and stored. The Director of Social Services was interviewed on 12/12/2023 at 3:25 PM and stated that they (Director of Social Services) did not have a Notice of Transfer to the hospital for Resident #75 when they were sent to the hospital on 10/21/2023 because they were not aware that they had to send one to the Office of the Long-Term Care Ombudsman when a resident was transferred/discharged to a hospital. The Director of Social Services stated that they only send a Notice of Transfer to the Office of the Long-Term Care Ombudsman when a resident is discharged home or to an assisted living facility. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 12/14/2023 at 1:35 PM and stated that the Social Worker was responsible to send a copy of the Notice of Transfer to the Office of the Long-Term Care Ombudsman on a monthly basis. The Admissions Department was responsible for notifying the resident's family in writing if they are in the building and by mail if the resident's family was not in the facility. The Administrator stated that in the case for Resident #75 the facility neglected to send the Notice of Transfer to the Ombudsman's Office, and they should have. 10 NYCRR 415.3(i)(1)(iv)(a-e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on observation, record review, and interviews during the Recertification Survey initiated on 12/10/2023 and completed on 12/14/2023, the facility did not ensure that each resident had a person-centered Comprehensive Care Plan (CCP) developed and implemented that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs. This was identified for one (Resident #21) of one resident reviewed for Skin Conditions (non-pressure). Specifically, Resident #21 had Physician Orders to receive treatments to bilateral lower extremities and an ACE wrap (compression bandages) to be applied to bilateral lower extremities. On 12/10/2023 during a tour of the 2nd floor Nursing Unit, the dressings to the lower extremities of Resident #21 were observed with a date of 12/8/2023. In addition, Resident #21 complained that the ACE wraps to their bilateral lower extremities were not applied to their legs for 2 days since 12/8/2023. The finding is: The policy titled: Medication and Treatment Orders dated 2023 does not include any criteria which addresses Treatment Orders. Resident #21 has diagnoses which include Congestive Heart Failure and Hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident had moderately impaired cognitive skills for daily decision making. The resident had venous and arterial ulcers present. The Physician Orders dated 11/17/2023 and last renewed 11/21/2023 documented to cleanse the Left Lower Extremity (LLE) with Normal Saline. Apply Alginate (absorbent wound dressing derived from seaweed) with a dry protective dressing (DPD) once daily (QD). The Physician Orders dated 11/17/2023 and last renewed 11/21/2023 documented to cleanse Right Lower Extremity (RLE), venous ulcer, with Normal Saline. Apply Xeroform (a sterile wound dressing) with a dry protective dressing daily. The Physician's Order dated 11/17/2023 and last renewed 11/21/2023 documented to wrap both LEs with an ACE wrap from the toes to the knees with the daily dressing changes. Resident #21 was observed on 12/10/2023 at 11:35 AM in their room seated in the wheelchair. Resident #21 was interviewed on 12/10/2023 at 11:35 AM and stated that their (Resident #21) ACE wraps were not put on for the past two days. Resident #21 showed the Surveyor the ACE wraps that were resting on top of the nightstand on the right side of their bed. Licensed Practical Nurse (LPN) #5 was interviewed on 12/10/2023 at 11:40 AM and stated that they (LPN #5) did not have the opportunity to do Resident #21's treatments yet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #2, the Unit Manager, was interviewed on 12/10/2023 at 11:53 AM and acknowledged that the bandages on both of the resident's lower extremities were dated 12/8/2023. RN #2 stated that the resident's treatments were not done yesterday (12/9/2023) and they should have been. RN #2 stated that they (RN #2) had worked the previous day and the LPN who had worked the 7 AM-3 PM shift, who was responsible for doing Resident #21's treatment, had not told them (RN #2) that they were unable to complete the resident's treatment yesterday. The 7 AM-3 PM LPN (LPN #6) who was responsible for doing Resident #21's treatments was interviewed on 12/10/2023 at 2:45 PM. LPN #6 stated that they were from an agency, and it was only their fourth time working at the facility on 12/9/2023. LPN #6 stated that it was their (LPN #6) first time working the 7 AM-3 PM shift and there were a lot of details to pay attention to that they (LPN #6) normally do not have to do on other shifts. LPN #6 stated that all the residents needed their blood pressure taken, one resident had a bacterial infection, and there were three residents receiving intravenous (IV) therapy. LPN #6 stated that it was impossible to complete everything on their (LPN #6) shift and they (LPN #6) were completely overwhelmed. LPN #6 stated that they (LPN #6) completed giving out all the residents' medications, wrote their Nursing progress notes, and went home. LPN #6 stated that they (LPN #6) did not tell anyone that they (LPN #6) were unable to finish the treatments for the residents, but they (LPN #6) should have. LPN #6 stated that they (LPN #6) were so overwhelmed that they (LPN #6) just wanted to leave and get out of the facility. LPN #6 stated that they (LPN #6) prioritized what was most important and did those things first. Review of the Treatment Administration Record (TAR) dated December 2023 revealed that LPN #6 had signed that they (LPN #6) had cleansed the resident's LLE with normal saline and applied Alginate with a dry protective dressing; cleansed the resident's RLE venous ulcer with normal saline and applied Xeroform with a dry protective dressing, and wrapped both of the resident's lower extremities with an ACE wrap on 12/9/2023. The Director of Nursing Services (DNS) was interviewed on 12/12/2023 at 12:36 PM and stated that LPN #6 should have informed the RN Supervisor that they needed assistance in completing the residents' treatments or let the residents' Physician know that the treatments were not performed. The DNS stated that they (DNS) were aware that LPN #6 signed the TAR that the treatments for Resident #21 were done, when they were not. The DNS stated that there was no way the facility would have known that the treatments were not done unless the resident brought it to the facility's attention the next day. The DNS stated that LPN #6 should not have signed the TAR for something they (LPN #6) did not do. LPN #6 was re-interviewed on 12/14/2023 at 1:24 PM and stated that if they (LPN #6) signed for Resident #21's treatments on 12/9/2023 then they (LPN #6) had done so in error. 10 NYCRR 415.11(c)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 12/10/2023 and completed on 12/14/2023, the facility did not ensure each resident received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. This was identified for one (Resident #327) of four residents reviewed for Accidents. Specifically, Resident #327 was observed on multiple occasions without the use of the Physician ordered ACE wraps or [NAME] (compression stocking) stockings to bilateral lower extremities due to complaint of pain and bilateral lower extremity edema. Additionally, when the ACE wrap was applied, the staff did not remove the ACE wraps as per the Physician's orders. The finding is: Resident # 327 has diagnoses of Edema, Cellulitis, and Diabetes Mellitus. The 11/21/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A nursing progress note dated 12/1/2023 at 7:25 AM documented the resident was noted with bilateral leg and foot Edema with minimum redness. No pain or skin breakdown was noted. A Nurse Practitioner (NP) ordered [NAME] (compression) stockings, and to keep the resident's legs elevated. The physician's order dated 12/1/2023 and renewed on 12/12/2023 documented to apply [NAME] stocking on bilateral leg/feet every day at 11:00 PM-7:00 AM; 3:00 PM-11:00 PM and 7:00 AM-3:00 PM and to monitor for skin breakdown. The medical progress note dated 12/1/2023 documented the resident was assessed status post fall in the morning and was complaining of left lower extremity pain. Left lower extremities X-rays were ordered. The medical progress note dated 12/1/2023 documented the left lower extremity X-rays indicated no Fracture. The nursing progress note dated 12/4/2023 at 6:49 AM documented the resident complained of lower extremity pain and swelling. Tylenol (pain medication) was administered as ordered this morning for pain. The nursing progress note dated 12/5/2023 at 3:06 PM documented the resident complained of foot edema which was noted with minimal redness with skin peel present. The resident was educated to keep their legs elevated. The medical progress note dated 12/5/2023 at 6:47 PM documented the resident complained of edema to the lower left ankle and foot. The resident was observed with Edema to the left lower extremities and was educated to elevate their legs daily when in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical progress note dated 12/6/2023 at 7:29 AM documented the resident complained of pain and was requesting to be put on morphine for their bilateral lower extremity pain. Resident was noted with Edema to the left lower extremity. The nursing progress note dated 12/6/2023 at 8:36 PM documented the resident requested to be placed on Lasix for swelling of the legs. The nurse spoke with the Nurse Practitioner who denied the resident's request. A nursing progress note dated 12/7/2023 at 7:59 AM documented that the resident complained and voiced concerns regarding their legs. The resident's legs were noted with excessive swelling and some redness. No hyperthermia (warmth) or pain was noted at this time. The resident was advised to elevate their legs. A call was placed to the Nurse Practitioner and the Physician. New orders were received for an Antibiotic for Cellulitis (inflammation) for seven days, and Lasix (a diuretic) 20 milligrams for seven days. A physician's order dated 12/7/2023 documented to apply ACE wraps to bilateral lower extremities every day at 9 AM due to complaints of Edema and to remove the ACE wraps every day at 9 PM. The medical progress note dated 12/8/2023 at 8:22 AM documented called in by the nurse to evaluate the resident for bilateral lower extremities edema. The left leg was noted red and was warm to touch, with pitting edema (occurs when excess fluid builds up in the body, causing swelling; when pressure is applied to the swollen area, a pit, or indentation, will remain). The nursing progress note dated 12/8/2023 at 2:18 PM documented the resident was alert and responsive. Keflex antibiotic was discontinued and the resident was to start with Doxycycline 100 milligrams twice a day for seven days for cellulitis of the legs. The medical progress note dated 12/8/2023 at 6:24 PM documented called in by the nurse to evaluate the resident's bilateral lower extremity edema, The left leg was noted red and was warm to touch with pitting edema and with increased level of pain. The plan indicated: Lasix 20 milligrams once a day and to change Keflex 500 milligrams due to allergic to penicillin and to start on Doxycycline 100 milligrams every 12 hours. Start the resident on Tramadol (pain medication) every 12 hours for the increased level of pain. On 12/10/2023 at 11:29 AM Resident #327 was observed sitting in their wheelchair in their room. The resident was not wearing the ACE wraps or [NAME] stockings to their lower extremities. The left lower extremity was observed to be red and both lower extremities were observed to be edematous (swollen with fluid). On 12/10/2023 at 1:11 PM Resident #327 was observed again sitting in their wheelchair in their room. The resident was not wearing the ACE wraps or [NAME] stocking to their lower extremities. The resident stated the ACE wraps have not been put on at all. On 12/10/2023 at 1:17 PM Registered Nurse (RN) #3 was interviewed. RN #3 stated they were in the process of completing the medication pass and would put the ACE wraps on the resident after completing the medication administration pass. RN #3 stated they were aware that the ACE wraps were supposed to be applied at 9 AM as per the Physician's orders; however, the ACE wraps were not applied because they (RN #3) were busy completing their medication administration pass. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/2023 at 10:33 AM Resident #327 was observed sitting in their wheelchair in their room. The ACE wraps were observed on the resident's lower legs. The resident stated the ACE wraps were applied yesterday afternoon (12/10/2023) and have not been taken off yet. A review of the December 2023 Treatment Administration Record (TAR) revealed that Licensed Practical Nurse (LPN) #4 signed the TAR indicating they removed the ACE wraps for Resident #327 on 12/10/2023 at 9 PM. The TAR also indicated the resident was wearing the [NAME] stockings every day from December 1st through December 12, 2023, every shift except on the following days: -On 12/1/2023 during the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM and 11:00 PM-7:00 AM shift. -On 12/7/2023 during the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shift. -On 12/11/2023 and 12/12/2023 during the 7:00 AM-3:00 PM shift the resident refused to wear the [NAME] stockings. Licensed Practical Nurse #2 (unit medication nurse) was interviewed on 12/11/2023 at 10:36 AM and stated they did not apply the ACE wraps this morning for Resident #327. Licensed Practical Nurse #2 stated there is a treatment nurse who will apply them. Licensed Practical Nurse (LPN) #3, the treatment nurse, was interviewed on 12/11/2023 at 10:46 AM and stated they had not applied the ace wraps yet today. LPN #3 stated they did not know the ACE wraps were on already. LPN #3 stated they were supposed to be removed last night. LPN #3 stated maybe the ACE wraps were put on very early in the morning by the overnight nurse, but the resident is very alert and could tell you when the ACE wraps were applied and removed. RN #4, who worked the 11 PM-7 AM overnight shift 12/10/2023-12/11/2023, was interviewed on 12/12/2023 at 8:46 AM and stated they did not apply the ACE wraps for Resident #327 during their shift. LPN #4 was interviewed on 12/12/2023 at 11:40 AM and stated on the night of 12/10/2023 there was a lot going on, but if they (LPN #4) signed for the ACE wraps being removed, then they (LPN #4) did it. LPN #4 stated they did not put the ace wraps back on, so LPN #4 stated they had no idea who put the ace wraps back on. The Director of Nursing Services (DNS) was interviewed on 12/13/2023 at 10:11 AM and stated the ACE wraps should have been applied at 9 AM as per the physician's order. The DNS stated it was a treatment order, so only nurses put the ACE wraps on. The DNS was informed that the 3 PM-11 PM nurse on 12/10/2023 signed for and stated they removed the ACE wraps, but none of the other nurses after that nurse's shift put them back on; however, the ACE wraps were observed on the resident in the morning of 12/11/2023. The DNS stated they were not aware that the ACE wraps were left on the resident's lower extremities all night. Certified Nursing Assistant (CNA) #2 on 12/13/2023 at 12:04 PM who worked 3 PM-11 PM on 12/10/2023 was interviewed. CNA #2 stated they did not recall anything about ace wraps. CNA #2 stated the nurses are responsible to apply and to remove the ACE wrap. 10 NYCRR 415.12

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Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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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** 34798 Based on observation, record review, and interviews during the Recertification Survey, initiated on 12/10/2023 and completed on 12/14/2023, the facility did not ensure 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 one (Resident #328) of two residents reviewed for Pressure Ulcers. Specifically, Resident #328 was admitted to the facility on [DATE] with a Stage 4 pressure ulcer to the right ischium (a bony prominence of the pelvis). Treatment for the Stage 4 pressure ulcer was not started until 10/23/2023. The initial wound assessment by the wound care Registered Nurse (RN) and the wound care physician documented an incorrect wound depth. Additionally, there was no intervention in the pressure ulcer Comprehensive Care Plan (CCP) or the Certified Nursing Assistant (CNA) care instructions to turn and position the resident. The finding is: The facility's policy titled Pressure Ulcer Care, revised 9/27/2023, documented based on the comprehensive assessment, a resident having a pressure ulcer receives necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from forming. It is the responsibility of the primary physician to order appropriate interventions (laboratory values, nutritional support, positioning devices, wound treatments); the responsibility of the Director of Nursing Services (DNS) is to confirm appropriate response, action, and documentation of nursing staff; the responsibility of the Registered Nurse (RN) is to document presence of skin ulcers on the Nursing Admission Assessment, initiate CCP, and notify wound care team of skin ulcer risk/presence, and obtain treatment orders; and the responsibility of the CNA is to follow the turning and positioning instructions in the nursing care profile. Resident #328 was admitted to the facility with diagnoses including Right Hip Fracture, Non-Alzheimer's Dementia, and Hypertension. The 10/17/2023 Admission Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS documented that the resident had one Stage 4 pressure ulcer and was at risk for developing pressure ulcers. The MDS documented the resident needed substantial/maximal assistance for rolling left and right, and for lying to sitting and sitting to lying, and was dependent for transfers. The 10/17/2023 hospital discharge instructions documented the resident had a Right Ischium pressure ulcer. Treatment instructions were to apply silver sulfadiazine cream (zinc oxide-based cream to promote wound healing) every 12 hours. There was no description of the wound in the discharge instructions. The 10/17/2023 Nursing Admission Assessment, completed by Registered Nurse #2, documented that the resident had a sacral wound that was moist. The size of the wound and the tissue description were not documented. The Braden score (a scale for predicting pressure ulcer risk) in the Nursing Admission Assessment was 17, indicating a mild risk for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/17/2023 Physician History and Physical, completed by Physician #1, documented the resident had a sacral decubitus ulcer (pressure ulcer). The physician documented the wound was unavoidable secondary to the resident physical status; to apply local wound care; the resident had fragile skin, and was at high risk for breakdown. A physician's order, entered by RN #2 and signed by Physician #1, dated 10/17/2023 documented an order for a wound care consultation. A review of the 48-hour care plan, effective 10/17/2023, documented no information or interventions related to the Right Ischium pressure ulcer. A CCP titled Skin Integrity: At Risk for Skin Breakdown, dated 10/17/2023, documented at risk for skin breakdown related to Braden scale score, decreased mobility, incontinence, edema, Anemia, or Malnourishment. The only intervention was to complete a pressure ulcer risk assessment and perform a quarterly review. The physician's order dated 10/23/2023 documented to cleanse the Ischial wound with normal saline, apply alginate (absorbent dressing typically derived from seaweed) dressing, and cover with dry protective dressing daily. A review of the October 2023 Treatment Administration Record (TAR) revealed that treatment for the right ischium wound was started on 10/23/2023. A CCP titled Wound Care Right Ischium, effective 10/23/2023 and last updated on 12/13/2023, created by RN #1 (the wound care nurse), revealed no intervention for turning and positioning the resident. The Resident Nursing Instructions (care instructions provided to the Certified Nursing Assistants) as of 12/13/2023 revealed no instructions for turning and positioning the resident. An entry for skin check/care, dated 10/17/2023, documented Decubitus/Pressure Ulcer Prevention-application of barrier cream. The first wound care physician note dated 10/24/2023 documented a Right Ischium Stage 4 pressure ulcer, present on admission, measuring 5 centimeters in length, 2.5 centimeters in width, and 0.1 centimeters in depth with a moderate amount of drainage. The wound treatment was to cleanse with normal saline, and apply alginate with a dry protective dressing. A preventative measure included to turn and position the resident every 2 hours. Certified Nursing Assistant (CNA) #1 was interviewed on 12/13/2023 at 8:09 AM. CNA #1 stated the resident needs assistance for turning and positioning and for transfers. The resident needs incontinent briefs and uses a urinal. CNA #1 stated they turn and position the resident every two hours, but they were not sure if it was in a care plan or if they (CNA #1) documented turning and positioning every two hours. Resident #328's wound care treatment was observed on 12/13/2023 at 9:08 AM performed by wound care treatment nurse, Licensed Practical Nurse (LPN) #3, and assisted by CNA #5. The resident had an air mattress and there was a Roho cushion observed on the resident's wheelchair. The Right Ischium wound appeared to be a deep wound with bone exposed. The wound had a moderate amount of serosanguinous (blood-tinged) drainage. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound measurements from the 12/12/2023 wound physician visit were documented to be 10 centimeters long x 4.5 centimeters wide x 1.5 centimeters deep. Wound Care RN #1 was interviewed on 12/13/23 at 1:26 PM. RN #1 stated the resident should be on an every two-hour turning and positioning program, even if this resident gets out of bed. When the resident is in bed, they should be turned and positioned and the intervention should be in the care plan and the nursing care instructions (CNA instructions). RN #2, the Admission Nurse, was interviewed on 12/13/2023 at 1:58 PM and stated when they do an admission and see a wound, they document that there is a wound, but do not categorize the stage of the wound. RN #2 stated the wound care team would assess the wound and then determine the current stage. RN #2 stated that it is the facility policy that if a wound is identified upon admission they (admission nurse) order a wound care consult through the Electronic Medical Record (EMR) to alert the wound care team. RN #2 stated they do not obtain treatment orders from the physician. The wound care team does an assessment and that is when the treatment orders are put in place. RN #2 further stated the wound care nurse and the DNS are here every day and they should evaluate the new admission residents the next day to complete an assessment and put in the treatment orders even if the wound care physician is not available. RN #1, the wound care nurse, was re-interviewed on 12/13/2023 at 2:23 PM and stated that the admission nurse should place the initial orders for wound care treatment as per the hospital discharge instructions until an assessment can be done by the wound care team. RN #1 stated the admission nurse has to document the presence of the wound in the resident's medical records, and then the assessment will be done by the wound care team. RN #1 stated they could not locate that an assessment of the Right Ischial wound was done prior to 10/23/2023 and could not explain why treatment orders were not in place until 10/23/2023. RN #1 was re-interviewed on 12/14/2023 at 10:33 AM and stated after reviewing the medical record they identified that they saw the resident on 10/18/2023 (day after admission). RN #1 provided a paper document entitled Skin Observation dated 10/18/2023. The Skin Observation form documented Right Ischium, Stage 4 (pressure ulcer) measuring 5.5 centimeters in length, 3.5 centimeters in width, and 0.1 centimeters in depth. RN #1 stated the Skin Observation document should have been uploaded to the EMR. RN #1 stated the hospital discharge instructions on 10/17/2023 required Silvadene treatment for the Right Ischial wound and that the treatment should have been done initially upon admission. RN #1 stated they should have ensured that the treatment orders were in place for the Right Ischial wound. Licensed Practical Nurse (LPN) #1, the clinical care coordinator/charge nurse, was interviewed on 12/14/2023 at 10:40 AM and stated they do not keep track of how often each resident is turned and positioned. Wound Care Physician #1 was interviewed on 12/14/2023 at 11:20 AM and stated that in their original wound care note dated 10/23/2023, they documented that the Right Ischial wound involved muscles and the wound depth should have been documented as 1 centimeter instead of 0.1 centimeters. The wound care physician stated they made an error in documenting the depth of the wound and are now going to correct their notes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was re-interviewed on 12/14/2023 at 11:39 AM and stated they reviewed the Skin Observation document dated 10/18/2023 and that the depth of 0.1 centimeters was incorrect. RN #1 stated the 0. 1-centimeter depth was a mistake and it should be 1.0 cm because the Right Ischial wound was observed with muscle involvement. The Director of Nursing Services was interviewed on 12/14/2023 at 12:03 PM and stated the admission nurse is supposed to enter the orders that were on the hospital discharge instructions. The Director of Nursing Services stated the assessment nurse can describe the wound but not stage it. The Director of Nursing Services further stated the wound care nurse has a responsibility to make sure the orders are in place. Primary Physician #1 was interviewed on 12/14/2023 at 12:10 PM and stated they do not know why the treatment orders were not put in place initially after admission and this may have been an oversight. Primary Physician #1 stated they steer clear of decubiti and the nurses know better when it comes to decubiti. Primary Physician #1 stated there is no reason to address something you know nothing about. 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 12/10/2023 and completed on 12/14/2023, 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 #425) of five residents reviewed for Respiratory Care. Specifically, Resident #425 had a Physician's order to receive 2 liters of oxygen per minute continuously. The resident was observed receiving 4 liters and 5 liters of oxygen per minute respectively on two consecutive days. The finding is: The facility's Administration and Maintenance of Oxygen policy revised June 2023 documented attending physicians are to provide a written order for the use of oxygen in non-emergency situations noting: the device to be used; the amount of oxygen flow; the duration of use; and the frequency the oxygen may be administered. The licensed nursing staff are to turn on the gauge and adjust the oxygen flow to the prescribed rate. Resident #425 was admitted with diagnoses including Acute Respiratory Failure, Pneumonia, and Nasal Congestion. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severely impaired cognition. The MDS further documented the resident was receiving oxygen therapy. A physician's order dated 12/10/2023 documented to administer oxygen at 2 liters per minute via a nasal cannula continuously every shift. No diagnosis was indicated for the use of oxygen. A physician's order dated 12/10/2023 documented to obtain a pulse oximeter (ox) saturation level every shift. The Comprehensive Care Plan (CCP) for Respiratory Disorder: Pneumonia dated 11/17/2023 documented an intervention to provide oxygen as ordered by the Physician. Resident # 425 was observed on 12/11/2023 at 11:21 AM while sitting in their wheelchair by their bed. Resident #425 was using a nasal cannula that was attached to an oxygen concentrator which was on the other side of the resident's bed. The oxygen concentrator was out of Resident #425's reach. The display window on the oxygen concentrator indicated Resident # 425 was receiving 4 liters of oxygen per minute. Resident #425 was interviewed on 12/11/2023 immediately after the observation stated that they breathed fine without oxygen and did not know why they remained on oxygen. Resident #425 stated that they felt that it was a nuisance to wear the oxygen tubing. The December Medication Administration Record documented on the 12/11/2023 day (7 AM - 3 PM) shift that Resident #425 was administered oxygen at 2 liters per minute continuously as evidenced by the staff signature. Resident #425's oxygen saturation rate was 97%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 425 was observed on 12/12/2023 at 2:18 PM while sitting in their wheelchair by their bed. Resident #425 was using a nasal cannula that was attached to an oxygen concentrator which was on the other side of the resident's bed. The oxygen concentrator was out of Resident #425's reach. The display window on the oxygen concentrator indicated Resident # 425 was receiving 5 liters of oxygen per minute. The December Medication Administration Record documented on 12/12/2023 day (7 AM - 3 PM) shift that Resident #425 was administered oxygen at 2 liters per minute continuously evidenced by staff signature. Resident #425's oxygen saturation was 97%. Resident #425 was observed on 12/12/2023 at 2:22 PM with Registered Nurse (RN) supervisor #5. RN #5 was the medication nurse on the unit. RN #5 confirmed that the oxygen concentrator was providing 5 liters of oxygen per minute at the time of the observation. RN #5 left the resident's room to check the resident's oxygen order, returned to the room, and dialed the oxygen setting down to 2 liters per minute. The sound of air flowing through the resident's nasal cannula was significantly reduced. RN #5 was interviewed immediately after the observation and stated that they checked Resident #425's oxygen at the start of the shift and the resident was receiving the oxygen at 2 liters per minute. RN #5 stated that they did not change the oxygen setting and did not know how the setting was dialed up to 5 liters per minute. RN #5 stated Resident #425 was ordered for continuous oxygen at 2 liters per minute for Acute Respiratory Failure. RN #5 further stated that the resident should be receiving oxygen at 2 liters per minute as per the Physician's order. Certified Nursing Assistant (CNA) #4, who was assigned to Resident #425 on 12/11/2023 and 12/12/2023, was interviewed on 12/13/2023 at 1:43 PM. CNA #4 stated that they did not change the oxygen setting on the resident's oxygen concentrator on either day. CNA #4 stated that they were not allowed to do so. CNA #4 stated that they would notify the nurse if they observed any abnormality with the oxygen device. The attending Physician (MD) #1 for Resident #425 was interviewed on 12/13/2023 at 12:18 PM. MD #1 stated that they would expect the resident to receive oxygen at 2 liters per minute as per the written order. The Director of Nursing Services (DNS) was interviewed on 12/13/2023 at 1:58 PM and stated they expected the licensed nurses to check and ensure that residents receive oxygen in the amount that was ordered at the beginning of each shift. The DNS stated that Resident #425 should receive oxygen at 2 liters per minute as per the MD order. 10 NYCRR 415.51(k)(6)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observation, record review, and interviews during the Recertification Survey initiated on 12/10/2023 and completed on 12/14/2023 the facility did not ensure each resident remained free of significant medication errors. This was identified for three (Resident #29, Resident #95, and Resident #92) of three residents reviewed for significant medication errors. On 12/10/2023 multiple residents received their medications late because the 11:00 PM-7:00 AM shift Licensed Practical Nurse #8 completed the medication administration pass late which then caused Licensed Practical Nurse #5 to administer medications to the residents late on the 7:00 AM-3:00 PM shift. Specifically, 1) Resident #29 received the physician ordered 6:00 AM and 6:30 AM pain medication and Thyroid medication at 8:02 AM, 2) Resident #95 received the physician ordered insulin and blood glucose check at 10:01 AM instead of 7:30 AM and also at 3:12 PM instead of 11:30 AM, and 3) Resident #92 received the physician ordered pain medication and Thyroid medication at 8:05 AM instead of 6:00 AM and also at 3:46 PM instead of 2:00 PM. The findings include, but are not limited to: The 7:00 AM-3:00 PM Licensed Practical Nurse (LPN) (LPN #5) was observed by a medication cart preparing medications to give to residents on 12/10/2023 at 11:40 AM on the 2nd Floor. LPN #5 was interviewed on 12/10/2023 at 11:40 AM and stated that they (LPN #5) were still giving out 9:00 AM medications at 11:40 AM because the 11:00 PM-7:00 AM LPN (LPN #8) had delayed them (LPN #5). LPN #5 stated that LPN #8 was still giving out medications until 9 AM and they (LPN #5) were unable to use the medication cart because LPN #8 was using it. LPN #5 stated that they came in at 7:00 AM but were unable to use the medication cart until 9:00 AM. LPN #5 stated that at 9:00 AM, they (LPN #5) first did the narcotic count, then blood pressure checks, then residents needing insulin with the residents' other medications at the same time, then residents who needed Tylenol, and then they (LPN #5) had to speak with a resident's family because the resident was getting intravenous (IV) fluids and the resident's family had questions. LPN #5 stated that they (LPN #5) were only about halfway through giving out all the 9:00 AM medications. The Administration Documentation Audit Detail Report dated 12/9/2023-12/10/2023 revealed 12 residents received their medications late during the 11:00 PM-7:00 AM shift on 12/10/2023. The Administration Documentation Audit Detail Report dated 12/10/2023 revealed 22 residents received their medications late during the 7:00 AM-3:00 PM shift on 12/10/2023. 1) Resident #29 has diagnoses that include Pain and Hypothyroidism. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9 which indicated that the resident had moderately impaired cognitive skills for daily decision making. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Order dated 9/15/2023 and last renewed 12/13/2023 documented for the resident to receive Acetaminophen (an analgesic drug used to relieve mild or chronic pain) 325 milligrams (mg) - give 2 tablets (650 mg) by oral route every 6 hours for Pain; Synthroid (a thyroid medication that replaces a hormone produced by your thyroid gland to regulate the body's energy and metabolism) 25 micrograms (mcg) by oral route daily for Hypothyroidism; and Tramadol (an opioid pain medication) 50 mg tablet every 8 hours for Unspecified Abdominal Pain. The Medication Administration Record (MAR) for December 2023 documented that the Acetaminophen, Synthroid, and Tramadol medications were given as ordered on 12/10/2023. The Administration Documentation Audit Detail Report documented on 12/10/2023 that Resident #29 received Acetaminophen and Tramadol at 8:02 AM instead of 6:00 AM and Synthroid at 8:02 AM instead of 6:30 AM. Resident #29 was interviewed on 12/14/2023 at 12:21 PM and stated when they receive their (Resident #29) pain medication late, they (Resident #29) are in pain. Resident #29 stated that they usually ring their call bell to get their medications when the medications are late. Resident #29 stated that they recall a few days ago when they had to wait to receive their Tylenol and Tramadol medications for their pain. Resident #29 stated that they (Resident #29) received their (Resident #29) pain medications late on that day (12/10/2023). The Director of Nursing Services (DNS) was interviewed on 12/14/2023 at 3:22 PM and stated that pain medications should be given timely. The DNS stated that a Nurse should notify their Registered Nurse (RN) Supervisor anytime when they are running late with giving out medications. The DNS stated that the RN Supervisor on the 11:00 PM - 7:00 AM was never made aware when LPN #8 was running late and should have been. The Medical Director was interviewed on 12/14/2023 at 3:35 PM and stated that if pain medications are not given timely, a resident may have discomfort. The Medical Director stated that the result of receiving pain medication late varies for each individual. The Medical Director stated that if the resident was feeling pain, that was what they were feeling. The Medical Director stated that there was no problem receiving Synthroid medication late. 2) Resident #95 has diagnoses that include Muscle Wasting and Atrophy and Type 2 Diabetes Mellitus without Complications. The admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6 which indicated that the resident had severely impaired cognitive skills for daily decision making. The Physician Order dated 10/2/2023 and last renewed 12/13/2023 documented for the resident to receive Metformin 1,000 milligrams (mg) tablet - give 1 tablet (1000 mg) by oral route 2 times per day with food every day at 5:00 PM and 9:00 AM for Type 2 Diabetes Mellitus. A Physician Order dated 11/14/2023 and last renewed on 12/13/2023 documented to administer Humalog KwikPen (U-100) Insulin 100 unit/milliliter (mL) subcutaneous, inject by subcutaneous route per prescriber's instructions. Insulin dosing requires individualization. Every Day at 11:30 AM; 4:30 PM; 7:30 AM. Protocol: For blood sugar (BS): 70-150=0 Units, 151-200=2 Units, 201-250=4 Units, 251-300=6 Units, 301-350=8 Units, 351-400=10 Units. Call Medical Doctor (MD) for BS less than 70 or greater than 400 for Type 2 Diabetes Mellitus. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record (MAR) for December 2023 documented the medications were given as ordered on 12/10/2023 and the resident's blood glucose level was 288 and 6 units of Humalog insulin were given at 7:30 AM and the resident's blood glucose level for 11:30 AM was 146 with no insulin given. The Administration Documentation Audit Detail Report documented that on 12/10/2023 the resident received the Humalog insulin and blood glucose check at 10:01 AM instead of 7:30 AM and at 3:12 PM instead of 11:30 AM. Resident #95 was interviewed on 12/14/2023 at 1:56 PM. Resident # 95 stated that it was important to get their insulin before meals. Resident #95 stated that at times the Nurses check their (Resident #95) blood glucose level after a meal and then their (Resident #95) blood glucose level was not accurate. The Director of Nursing Services (DNS) was interviewed on 12/14/2023 at 3:25 PM and stated that Breakfast is served at 7:30 AM. The DNS stated that blood glucose checks should be done before meals and insulin should also be given before meals. The Medical Director was interviewed on 12/14/2023 at 3:41 PM and stated that blood glucose levels should be done before meals. 3) Resident #92 has diagnoses that include Pain and Hypothyroidism. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated that the resident had moderately impaired cognitive skills for daily decision making. The Physician Order dated 10/15/2023 and last renewed 12/7/2023 documented for the resident to receive Oxycodone (an opioid medication used to treat moderate to severe pain) 5 milligrams (mg) tablet give 1 tablet (5 mg) by oral route every 8 hours for 14 days at 10:00 PM, 2:00 PM, and 6:00 AM for Pain and Synthroid (a thyroid medication that replaces a hormone produced by your thyroid gland to regulate the body's energy and metabolism) 75 micrograms (mcg) daily at 6:00 AM for Hypothyroidism. The Medication Administration Record (MAR) for December 2023 documented that the Oxycodone and Synthroid medications were given as ordered on 12/10/2023. Oxycodone was to be given at 6:00 AM, 2:00 PM, and 10:00 PM and Synthroid at daily at 6:00 AM. The Administration Documentation Audit Detail Report documented that on 12/10/2023 the resident received the Oxycodone and Synthroid medications at 8:05 AM instead of 6:00 AM and 3:46 PM instead of 2:00 PM. Resident #92 was interviewed on 12/14/2023 at 1:58 PM. Resident #92 stated that when they receive their pain medication late, they are in pain. The Director of Nursing Services (DNS) was interviewed on 12/14/2023 at 3:25 PM and stated that the resident's Synthroid medication should have been provided before meals in the morning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medical Director was interviewed on 12/14/2023 at 3:35 PM and stated that if pain medications are not given timely, a resident may have discomfort. The Medical Director stated that the result of receiving pain medication late varies for each individual. The Medical Director stated that if the resident was feeling pain, that was what they were feeling. The Medical Director stated that there was no problem receiving Synthroid medication late. The Assistant Director of Nursing Services (ADNS) #2 was interviewed on 12/14/2023 at 3:59 PM and stated that LPN #8 should have notified their Registered Nurse (RN) Supervisor when they (LPN #8) required assistance with medication administration. The 11 PM-7 AM LPN (LPN #8) was interviewed on 12/14/2023 at 3:46 PM and stated that they (LPN #8) were late in giving out medications because they had to help the Certified Nursing Assistants (CNAs) give care to residents and then started the medication pass late. LPN #8 stated that there was also a resident that could not breathe, and they (LPN #8) had to look for an oxygen tank. LPN #8 stated it was their first day working and did not know where to find an oxygen tank in the facility. LPN #8 stated that since it was their (LPN #8) first day working at the facility, they had to learn all the residents and the Electronic Medical Record (EMR) system. LPN #8 stated that they (LPN #8) should have called the RN Supervisor but did not know who to call. LPN #8 stated that by starting the medication pass late, this caused a [NAME] effect that impacted the other Nurse on the following 7:00 AM-3:00 PM shift. LPN #8 stated that they completed their medication pass at 9:00 AM. LPN #8 stated that they (LPN #8) were not aware that they (LPN #8) should have called the RN Supervisor but knew to go through the chain of command. LPN #8 further stated that there was a Charge Nurse on their (LPN #8) shift but they did not want to bother them. 10 NYCRR 415.12(m)(2)