STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335261	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Paramount at Somers Rehab and Nursing Center	Route 100 Somers, NY 10589

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48847 Based on observation, record review, and interviews conducted during the recertification survey from 10/31/24 to 11/07/24, the facility did not ensure that they treated each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for one (Resident #66) of two residents reviewed for dignity. Specifically, Resident #66's room was located on the first floor and looked out to the staff parking lot. The window had a broken screen and a broken window shade that was fully up and could not be pulled down to provide the resident with privacy. The findings are: The facility policy titled Window safety Policy dated 7/20/21 and revised on 06/2023 documented that is the facility policy that all facility windows be maintained in a safe and functional order, and the windows will be provided with blinds and insect screens. If a blind or screen needs repair, the facility will utilize and third-party vendor to repair/replace blind or screen. Resident #66 was admitted with diagnoses including diabetes mellitus, insomnia, and major depressive disorder. The 9/29/24 Quarterly Minimum Data Set documented Resident #66 had moderately impaired cognition and was dependent on staff for bed mobility and toileting. On 10/31/24 at 10:32 AM, Resident #66 was observed in bed awake. The window shade was observed broken and fully raised and the insect screen was completely torn from the window parameter. Resident #66 stated that they were upset about their window, and that they wanted the shade down, but it was broken and that it had been like that for over a week. They stated the screen had been torn since they came to the facility. During an interview on 10/31/24 at 10:32 AM, Resident #213, roommate of Resident #66 stated that the window shade was broken, and they had to keep the curtain between the beds closed all the time because the light shines through the room all day and night. On 11/04/24 at 12:09 PM, Resident #66 was observed in bed. The window shade and screen was still broken and had not been repaired. Resident #66 stated that no one came into their room to address it. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 11:32 AM, Certified Nurse Aide #21 stated that they were aware that Resident #66's window shade was broken, and they should have reported it to the unit clerk or the charge nurse so that a work order could have been initiated. Certified Nurse Aide #21 stated Resident #66's room was located near the staff parking lot and when they provided cares, the shade should be down to give the resident privacy. During an interview on 11/06/24 at 09:32 AM, the Director of Maintenance stated that they were not aware that Resident #66's window shade or screen was broken until 11/5/24 and that they repaired the shade because it was fully up and unable to come down. During an interview on 11/06/24 at 04:58 PM, the Director of Nursing stated residents should be provided privacy upon request, including having their window shades closed when being provided cares. 10 NYCRR 415.5(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48847 Based on observation, record review, and interviews conducted during the recertification survey from 10/31/24 to 11/07/24, the facility did not ensure that each resident who was unable to carry out activities of daily living (ADL) received the necessary care and services to maintain good personal hygiene for one (Resident #226) of six residents reviewed for Activities of a Daily Living. Specifically, Resident #226 required total assistance with Activities of a Daily Living cares by facility staff, did not receive Activities of a Daily Living cares on multiple shifts, according to the October 2024 Certified Nurse Aide documentation. A private duty aide stated they provided all the cares for the resident 8 hours a day, 7 days a week. The findings are: The Private Duty/Companion Education Guidelines for Facility Entry, Exit and Visit documented that private duty/companions are not permitted to provide resident care at any time during their visit. Resident #226 was admitted with diagnoses including but not limited to dementia, Parkinson's disease, and seizures/epilepsy. The 10/05/24 Significant Change Minimum Data Set documented Resident #226 had severely impaired cognition, required total assistance with eating, toileting, and personal hygiene, and required supervision with bed mobility. The 4/30/24 Activities of a Daily Living Care Plan documented Resident #226 required assistance with activities of daily living related to dementia and impaired balance. Interventions included Resident #226 was to receive substantial/maximal assistance from one staff with bed mobility, transfers, toileting, and bathing as required. Review of the October 2024 Certified Nurse Aide Documentation Survey Report revealed on 10/4/24(3 PM-11 PM and 11 PM-7 AM shifts), 10/6/24(11 PM-7 AM shift), 10/11/24(11 PM-7 AM shift), 10/12/24(7 AM-3 PM shift), 10/14/24(11 PM-7 AM shift), 10/17/24(7 AM- 3 PM and 11 PM-7 AM shifts), 10/18/24(7 AM-3 PM shift), 10/25/24-10/28/24(11 PM-7 AM shift), and 10/26/24(7 AM-PM shift), there was no documented evidence tasks including but not limited to applying barrier cream for incontinent episodes, bladder/bowel, chair / bed to chair transfer incontinence care, eating, oral hygiene, toileting, personal hygiene, and showering/bathing were performed. Staff signatures were lacking for multiple tasks. On 10/31/24 at 10:01 AM, Resident #226 was observed lying in their bed while being assisted with their breakfast by a private duty aide. Then the private duty aide proceeded to wash Resident #226's face and stated that they were going to wash them up. The private duty aide was interviewed during the observation and stated they were at the facility 7 days a week for approximately 8 hours, and they did all of Resident #226's cares, and assisted them with their meals while they were there. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/05/24 at 11:22 AM, Certified Nurse Aide #27 stated they usually assisted Resident #226 with activities of a daily living in the morning before the private aide arrived and after lunch. They stated when the private duty aide was at the facility, the private duty aide provided cares. Certified Nurse Aide #27 stated the private duty aide was overbearing, and that they should be reporting to the nurses when the private duty aide was providing cares, as they were not allowed to provide cares. Certified Nurse Aide #27 stated that when they document in the certified nurse aide documentation, it was indicating that they provided the care and that if they did not provide care, they should not document that they did. During an interview on 11/06/24 at 12:54 PM, the private duty aide stated that prior to 11/5/24 they did everything for Resident #226, like feeding and bathing them. The private duty aide stated that on 11/5/24 they were given a document by Licensed Practical Nurse Manager #22, that they were not to provide any cares to Resident #226. The private duty aide stated they were very upset because Resident #226 only knew them. The private duty aide stated that they fed Resident #226 as the resident would only open their mouth for them. The private duty aide also stated they provided toileting every two hours and transferred Resident #226 to their wheelchair. During an interview on 11/06/24 at 1:09 PM, Resident #47 (spouse/roommate of Resident #226) stated that the private duty aide did a good job with Resident #226 and that the private aide put protective cream on Resident #226's bottom to protect their bottom from sores and Resident #226 had no sores because of the private duty aide. During an interview on 11/06/24 at 4:43 PM, the Director of Nursing stated that private duty aides should not be providing cares to residents. They stated the private duty aide had been non-compliant with the facility policy on private duty aides. Licensed Practical Nurse Manager #22 had numerous conversations with Resident #226's family about the private duty aide providing cares despite knowing that they were not allowed to. The Director of Nursing stated that there should be nursing documentation on communication and non-compliance with the private duty aides. The Director of Nursing stated that the certified nurse aides must provide all cares to Resident #226 and if they could not provide cares due to interference from the private duty aide, they should have reported to the nurse. During an interview on 11/07/24 at 01:49 PM, Licensed Practical Nurse Manager #22 stated that private duty aides should not be providing cares to residents and that they spoke to staff and told them to report to nurses if the private duty aides were noncompliant. Licensed Practical Nurse Manager #22 stated that the certified nurse aides should be following the plan of care and documenting in the certified nurse aide documentation. If the documentation was not signed off on, then it was not done. 10 NYCRR 415.12(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review, and interview conducted during the recertification and abbreviated surveys (NY00338981) from 10/31/24 to 11/07/24, the facility did not ensure the residents' environment remained as free of accidents hazards as possible for 2 (Residents #631 and #226) of 10 residents reviewed for accidents. Specifically, 1) Resident #631 had a physician order for a pureed diet with nectar thick liquids, and was able to consume thin liquids and a cookie while in a supervised area, and required oral suctioning to clear their throat. 2) Resident #226 had an electric air mattress overlay, on top of their mattress, that was not inspected by the maintenance department for safety until after the start of survey. The findings are: 1) Resident #631 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, dementia, and dysphagia (difficulty swallowing). The Minimum Data Set (an assessment tool) dated 3/8/24 documented the resident had impaired cognition, required supervision for eating and was totally dependent on staff for activities of daily living. The physician orders dated 3/4/24 documented pureed diet with nectar thick liquids. The Speech Pathologist assessment dated [DATE] documented the resident exhibited mild prolonged mastication, holding of food and frequent throat clearing after swallow. They recommended to continue with pureed diet and nectar thick liquids with close supervision. The care plan for dysphagia dated 3/5/24 documented the goal was the resident would tolerate the least restrictive diet consistency with no aspiration to maximize nutrition and improve quality of life. There were no interventions documented for this care plan. An accident and incident report dated 3/9/24 documented the resident was sitting at the table in the common area with their family. The family fed the resident their meal at the table. Cookies from another resident were on the table at this time. The family finished feeding the resident, removed the tray, and left the cookies in the resident's reach. At 4:30PM, the resident ate the cookies and staff moved the resident into their room and performed oral suctioning. Certified Nurse Aide #4's written statement dated 3/10/24 documented on 3/9/24 at 4:00 PM, they walked by a table in the common area and saw another resident give Resident #631 thin liquids. They (Certified Nurse Aide #4) immediately took it away, saw the resident was aspirating and yelled to the other Certified Nurse Aide for the nurse. After they (nurse) suctioned, Certified Nurse Aide #4 kept the resident upright in their chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #3's progress note dated 3/10/24 at 12:10 AM, documented another staff member informed them Resident #631 was choking. The resident was seated in the common area by the nurses' station and had a half-eaten solid cookie with nuts on the table in front of them. Cookie crumbs and nuts were scattered on her lap and the resident was holding her dentures. With the assistance of another nurse, the resident was taken to their room and suctioned. Nuts and a large amount of mucus was extricated from her oral cavity and esophagus; the resident was able to clear their throat. During an interview on 10/31/24 at 3:30PM, Certified Nurse Aide #4 stated the resident on their assignment the evening of 3/9/24. At 4:30 PM the resident was in the Common Area as they were new to the facility and staff observed this area. Certified Nurse Aide #4 stated while in the Common Area they saw Resident #631 having trouble and coughing and called out loud for a nurse. Licensed Practical Nurse #3 and Licensed Practical Nurse #7 came over and assisted. The two nurses took the resident into their room and did oral suctioning. They stated they were not aware of any staff assigned to supervise the area; everyone was supposed to supervise the area. During an interview on 10/31/24 at 4:50PM, Registered Nurse Unit Manager #1 stated the residents in the Common Area were never left unsupervised. There was always one staff member in the area and did not know how the resident was able to eat a cookie in this area. They stated someone should have been there watching the residents. 48847 2) Resident #226 was admitted with diagnoses including dementia, Parkinson's disease, and seizures/epilepsy. The 10/05/24 Significant Change Minimum Data Set (assessment tool) documented Resident #226 had severely impaired cognition, required total assistance with eating, toileting, and personal hygiene, and required supervision with bed mobility. During an observation on 10/31/24 at 10:01 AM, Resident #226 was lying in bed on top of an electric air mattress overlay, that was on top of their mattress. The air mattress overlay was plugged in to the electrical outlet and there was not a maintenance sticker on the equipment. The private duty aide, who was at Resident #226's bedside, was interviewed during the observation and stated that they brought the air mattress overlay in from home. They stated they asked the facility to provide the resident with an air mattress and the facility refused. The private duty aide stated they brought the air mattress overlay in a few weeks ago, they were unsure of the exact date, and staff were aware they brought it in. The 11/1/24 Physician order documented Resident #226 was to receive an air mattress. During an interview on 11/05/24 at 11:22 AM, Certified Nurse Aide #27 stated that they were aware that Resident #226 had an air mattress overlay from the private duty aide and they assumed that facility knew about it. Certified Nurse Aide #27 stated that if they knew the air mattress overlay was not allowed, they would have reported it immediately to their supervisor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/24 at 4:43 PM, the Director of Nursing stated they were aware Resident #226 had an air mattress on their bed and they thought the air mattress was provided by the facility. They stated they were unaware, until today, that the air mattress overlay was brought in by the private duty aide. The Director of Nursing stated any electrical equipment including air mattress overlays, brought into the facility, should be checked by maintenance. During an interview on 11/07/24 at 9:21 AM, the Director of Maintenance stated that they were first made aware on 11/1/24 that Resident #226 had an air mattress overlay on their bed. They stated when visitors brought in electrical equipment for residents, the visitors were supposed to check in with the receptionist. The maintenance department would be notified and would assess the equipment for safety and put a sticker on it. They stated until the electrical equipment was evaluated and approved by the maintenance department, it was considered unsafe for the resident to use. During an interview on 11/07/24 at 1:49 PM, Licensed Practical Nurse Unit Nurse Manager #22 stated that they received a verbal order from the physician to put the order in for the air mattress on 11/1/24. They stated that Resident #226's private duty aide had requested an air mattress for Resident #226 on multiple occasions. Licensed Practical Nurse Unit Nurse Manager #22 stated that they were not aware the resident had the air mattress overlay until the private duty aide told them that the surveyor asked about it. 10 NYCRR 415.12 (h)(1) 49255

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on record review and interviews conducted during the recertification and abbreviated (NY00349833) surveys from 10/31/24 to 11/7/24, the facility did not ensure a resident who was fed by enteral means (delivery of nutrients through a feeding tube directly into the stomach) received the appropriate treatment and services to prevent complications for 1 of 1 resident (Resident #182) reviewed for tube feeding. Specifically, the facility did not have the physician prescribed gastrostomy tube size available. The findings are: The facility November 2018 policy titled Changing a Percutaneous Endoscopic Gastrostomy Tube, documented assemble equipment and supplies needed, and gastrostomy tube (size ordered by physician). Resident #182 was admitted with diagnoses which included aphasia, respiratory failure, and gastrostomy status. The 6/7/24 Quarterly Minimum Data Set (resident assessment) documented Resident # 182 had severely impaired cognition, and received feeding via a feeding tube 51% or more. The Physician's Dietary Orders documented 3/27/24 NPO (nothing by mouth). 4/6/24 Enteral feed 2 times a day auto water flush 640 mls/day (80 mls/hr X 8 hours) hang at 10 pm, down at 6 am. 5/7/24 Enteral Feed 3 times a day Jevity 1.5 1659 ml via PEG. 237 ml bolus feed 7X day (6 am, 8am, 11 am, 2 pm, 430 pm, 630 pm, 930 pm. 50 ml water flush after/prior to meals 700 ml/day) 80 ml water flush X 8 hours overnight. Tube feed provides 2489 kcals, 106 gm protein, 2601 ml free water, 2999 ml total fluid. The Care Plan titled Resident requires tube feeding for nutritional support, dysphagia, inability to consume adequate food, updated 6/14/24, documented provide tube feeding as ordered 237 mls bolus feed 7X/day (6 am, 8 am, 11 am, 2 pm, 430 pm, 630 pm, 930 pm) after/prior to meals flush 50 mls, 80 ml water flush X 8 hours overnight. Tube feed 2489 kcals 106 gm protein, 2600 ml free water, 2999 ml total fluid volume, provide water flush as ordered, provide water flush with medications per nursing policy. The 7/20/24 at 14:16 Nursing Progress Note by Licensed Practical Nurse Unit Manager #8 documented resident's g-tube balloon broke and g-tube came out. The Nurse Practitioner was made aware and ordered to put in a 20 French. Does not fit. The Nurse Practitioner was made aware and ordered to send resident to hospital. 18 French Foley inserted to keep open. Resident's sister made aware. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/22/24 at 10:15 Nursing Progress Note by the Assistant Director of Nursing documented they were called to the unit to assess resident's g-tube, as the nurse was unable to flush. Attempts to flush tube and de-clog were unsuccessful. Resident showing no signs of pain or discomfort. Current g-tube size is 18 French placed in emergency roiagnom on [DATE]. Upon attempt to remove 18 French g-tube resident showed minor discomfort and tube resisted being removed from site. New g-tube placed 14 French without issue. G-tube flushed without issue. The Nurse Practitioner was informed of g-tube placement and new size. New order: abdominal ultrasound to check placement. The 7/22/24 at 20:46 Nursing Progress Note by Registered Nurse Supervisor #9 documented Resident 14's French g-tube clogged and was unable to be cleared on this shift. Prescribed size 18 French catheter insertion attempted and failed. G-tube replaced with 14 French catheter. Resident tolerated the procedure well. Confirmed audible, no residual noted. The 7/23/24 at 16:06 Nurse Practitioner Note by Nurse Practitioner #2 documented an 18 French g-tube was successfully placed by the writer. During the tube placement, the resident's sister was present at the bedside and expressed gratitude. Gastrointestinal: no abdominal pain, nausea, vomiting, or diarrhea. No distress. Abdomen soft, positive bowel sounds, non-tender, no palpable masses. Continue Jevity 1.5 (1659 ml/d) bolus feed, 7 times per day with water flushes. The Medline Purchase Order dated 7/20/24 documented one 18-gauge gastrostomy tube with a delivery date of 7/25/24. The Medline Packing List with an order date of 7/22/24 documented a ship date of 7/22/24 documented one 18-gauge gastrostomy tube. The Master Packing Slip dated 7/30/24 documented one 18-gauge gastrostomy tube was shipped, ship date 7/30/24. The 7/22/24 at 8:42 AM email from the Director of Housekeeping and Central Supply to the Purchasing Manager documented they placed an order for an 18-gauge gastrostomy tube which is urgently needed. The Medline Purchase Order dated 7/20/24 documented one 18-gauge gastrostomy tube was ordered and was approved by the Purchasing Manager on 7/22/24 at 11:32 AM. On 11/1/24 at 11:45 AM during an interview, the Director of Housekeeping and Central Supply stated their inventory should always be two 18-gauge gastrostomy tubes. They stated they ran out of stock of 18-gauge gastrostomy tubes on Saturday, 7/20/24. They stated Licensed Practical Nurse Unit Manager #8 called them on 7/20/24, asking for an 18-gauge gastrostomy tube, and they did not have one. The Director of Housekeeping and Central Supply stated that also on Monday 7/22/24, Licensed Practical Nurse Unit Manager #8 called them and asked for another 18-gauge gastrostomy tube, and they did not have one. The Director of Housekeeping and Central Supply stated they believe they ran out of the 18-gauge gastrostomy tubes because staff might not have signed out on the Supply Take Out Sheet when they removed them from stock. They stated they check their inventory every Monday but do not keep records of their inventory. They further stated they do not know how long their stock was at zero 18-gauge gastrostomy tubes. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/4/24 at 2:51 PM during an interview, Licensed Practical Nurse Unit Manager #8 stated that on 7/20/24 there was no 18-gauge gastrostomy tube in the facility, they stated they called the Director of Housekeeping and Central Supply for assistance in finding the 18-gauge gastrostomy tube but could not one, then they called Nurse Practitioner #2 to tell them they did not have an 18-gauge gastrostomy tube, and Nurse Practitioner #2 ordered to insert a 20 gauge gastrostomy tube but that did not fit. They stated Nurse Practitioner #2 then ordered to insert an 18-French Foley catheter and send the resident to the emergency room for a new 18-gauge gastrostomy tube to be inserted. Licensed Practical Nurse Unit Manager #8 stated that when they run out of a supply on the unit, they notify the Director of Housekeeping and Central Supply or the Nursing Supervisor. On 11/4/24 at 5:16 PM during an interview, the Assistant Director of Nursing stated that on 7/22/24 a 14-gauge gastrostomy tube was inserted because the facility did not have an 18-gauge gastrostomy tube. They stated the Director of Housekeeping and Central Supply is responsible to stock all necessary items. On 11/4/24 at 5:51 PM during an interview, Registered Nurse Supervisor #9 stated that on 7/22/24 a 14 French catheter was inserted because the 18-gauge gastrostomy tube would not fit, and they informed Nurse Practitioner #2 that the 18-gauge gastrostomy tube would not fit. On 11/4/24 at 6:08 PM during an interview, Nurse Practitioner #2 stated the resident was sent to the emergency roiagnom on [DATE] to replace the gastrostomy tube because the facility did not have an 18-gauge gastrostomy tube. Nurse Practitioner #2 stated that on the evening of 7/22/24, a 14-gauge gastrostomy tube was inserted because an 18-gauge gastrostomy tube would not fit which might have been due to the Resident's abdominal opening becoming smaller from having the smaller (14-gauge) tube in the opening. On 11/5/24 at 10:08 AM during an interview, the Director of Nursing stated the facility should keep a stock of appropriately sized gastrostomy tubes for residents in the facility. They stated that a gastrostomy tube replacement should be replaced with the same size gastrostomy tube. On 11/5/24 at 10:53 AM, during a follow up interview with the Director of Housekeeping and Central Supply, they provided a Medline Purchase Order dated 2/18/24 which documented one 18-gauge gastrostomy tube was ordered in February 2024, and stated that no other purchase order was documented. The Medline Purchase Order dated 7/20/24 documented one 18-gauge gastrostomy tube was not approved on 7/22/24 until 11:32 AM. 10 NYCRR 415.12(g)(2)

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The Paramount at Somers Rehab and Nursing Center	Route 100 Somers, NY 10589

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44673 Based on observation, interview and record review conducted during the recertification and abbreviated surveys (NY00351352) from 10/31/24- 11/7/24, the facility did not ensure that sufficient nursing staff was consistently provided to meet the needs of residents on all shifts. Specifically, 1) Multiple residents reported during interviews and the Resident Council Group meeting that the facility was short staffed at times, 2) Several nursing staff members reported lack of sufficient staffing to provide care to the residents, and 3) a review of the actual staffing sheets from 10/1/24 to 10/31/24 showed that on multiple occasions the facility was below the minimum levels documented on the Facility Assessment. Findings include: The Payroll Base Journal, Quarter 1 2024 (October 1 - December 31), documented a one star staffing rating and excessively low weekend staffing. The facility staffing sheets from 10/1/24-10/31/24 and the Facility Assessment, for residents to direct care nursing staff ratios, documented the facility was understaffed 19 days of 31 days covering various shifts as reviewed for direct care nursing staff. In addition, on 10/1, 10/2, 10/3, 10/5, 10/6, 10/7, 10/10, 10/12,10/13, 10/15, 10/16 10/19, 10/20, 10/21, 10/23, 10/24, 10/27 and 10/31 there was only one Certified Nurse Aide scheduled to work on the night shift on various units. During a Resident Council meeting on 11/1/24 at 11:28 AM, Resident #31 stated they had experienced falls because when they rang the call bell, response time was lengthy, and lead to them to try to manage on their own. During an interview with Resident #381 on 11/6/2024 at 9:50 AM, they stated the facility was always short staff especially on the night shift and on the weekend. They stated when they rang the call bell it took the staff about 15 minutes to answer, and they always seemed rushed. During an interview with the Staffing Coordinator on 11/6/24 at 9:55 AM, they stated they utilized agencies to help with staffing, offered incentives and bonuses, had eight-hour shifts and staff worked every other weekend. However, they continued to struggle to staff the facility especially on the night shift and the weekends. During an interview with Certified Nurse Aide #21 on 11/6/2024 at 10:00 AM (West Unit), they stated staffing was awful. They stated the unit census was 50 residents, and on some days they work with two aides and that affected the quality of care they provided to the residents. During an interview with Certified Nurse Aide #20 on 11/6/2024 at 10:15 AM (West unit), they stated the unit was short staffed most of the time especially at night when the unit was staffed with only one aide. They stated the residents did not get the care they needed. They further stated they did a double shift for the facility at least four times per week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse #18 on 11/6/2024 at 10:45 AM (Berkshire Unit), they stated staffing was short. They stated the unit census was 39 residents. They stated on the night shift and on weekends the facility did not have enough aides and it affected resident care resulting in skin issues and longer wait time to answer call bells. During an interview with the Director of Nursing on 11/6/2024 at 11:00 AM, they stated staffing could be better. They stated they were struggling with staffing and offered a Certified Nurse Aide Training Program, incentives program, and bonus programs. During an interview with the Administrator on 11/6/2024 at 11:15 AM, they stated the facility assessment reflected the best numbers and the minimum numbers. They stated they were trying to get more staff. They stated they had a Certified Nurse Aide Training Program that ran monthly, and some aides remained at the facility as hired staff. 10NYCRR 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** 51214 Based on observation and interview conducted during a recertification survey from 10/31/24-11/7/21, the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards, labeling and the expiration date. Specifically, expired medications were found in the medication cart on one of five units (Westminister Unit) and unlabeled medication was found in the medication storage refrigerator on one of four units ([NAME] Unit) observed for medication storage. The findings are: During observation on 11/6/24 at 4:50 pm of the medication storage room refrigerator #3 on the [NAME] Unit, two boxes of Ascor were found in a plastic bag. The two boxes of Ascor and the plastic bag did not contain a resident name and pharmacy label. There was one bag containing three boxes of Ascor that had the resident name and pharmacy label. During an interview on 11/6/24 at 4:50 pm Licensed Practical Charge Nurse #16 stated all Ascor was ordered for the same resident and should be in the bag that was labeled with the resident name and pharmacy label. During observation on 11/6/24 at 4:54PM of one medication cart on the Westminister Unit, 1 blister pack containing 27 capsules of Nexium DR 40 mg were found. The blister pack pharmacy label documented the name of Resident # 224, give 1 capsule via peg one time daily. The blister pack was dated 6/6/23. The blister pack documented a 6/6/24 expiration date. The left top corner of the blister pack had a documented hand written date of 10/28/24. During an interview on 11/6/24 at 5:00 pm Registered Nurse #17 stated the resident was no longer receiving the Nexium. They stated the medication had been discontinued, but they were uncertain when it was discontinued. They stated medication that is discontinued and/or expired should be pulled from the medication cart, brought to the Director of Nursing to be scanned (barcode), and returned to the pharmacy by way of pick up. They stated the Unit Manager was responsible for going through the medication cart and removing expired or discontinued medications. They stated medications pulled out of carts during off hours should be brought to the nursing office. During an interview on 11/7/24 at 3:35 pm the Director of Nursing stated the Pharmacy Consultant checks the medication carts monthly (medications/contents). The Director of Nursing stated the Unit Managers and Charge Nurses do weekly checks of the medication cart/s. They stated medications that had been discontinued and expired should go back to the nursing office, scanned into the portal and sent back to the pharmacy. 10 NYCRR 415.18

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49255 Based on observations and interviews conducted during the recertification survey from 10/31/24 to 11/7/24, the facility did not ensure storage of food in accordance with professional standards for food service safety for 1 of 1 kitchen (the main kitchen) reviewed. Specifically, the kitchen walk-in freezer insulation door seals were not attaching properly causing formation of ice on the freezer's floor, the freezer's door, and plastic curtain inside the freezer. Finding include: The facility policy Walk-in freezer/refrigerator dated 8/21/20 documented proper maintenance of the walk-in freezer is crucial for food safety, energy efficiency, and the longevity of the facility's equipment. Daily maintenance tasks included but not limited for door seal inspection to ensure door seals and gaskets are functioning properly. Monthly Maintenance Tasks included insulation inspection to check insulation and make necessary repairs. During an initial tour of the kitchen on 10/31/24 at 9:53 AM, conducted with Food Service Director, the walk-in freezer was observed with ice accumulation on inside door surface, the freezer's floor, and the inner plastic curtain. During an interview on 10/31/24 at 10:17 AM, the Food Services Director stated the insulation seals were not attaching properly to the door, leaving a gap between the door and door's frame, and causing formation of ice inside the freezer. They stated they placed a request to the contractor to fix the door seals. 10NYCRR 415.14(h)