STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335555	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Heights Nursing and Rehabilitation Center	378 Syosset Woodbury Road Woodbury, NY 11797

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 28173 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure that each resident was treated with respect and dignity and in a manner that promotes maintenance or enhancement of his or her quality of life. This was identified 1) on nine of nine units during the dining task observations and 2) for seven (Resident #169, Resident #341, Resident #285, Resident #5, Resident #267, Resident #337, and Resident #204) of seven residents interviewed during the resident council meeting. Specifically, 1)during the dining task observations, residents on all nine units were served their breakfast and lunch meals on disposable plates with disposable utensils. 2) On 10/16/2024 at 2:30 PM, all seven residents who attended the resident council meeting verbalized dissatisfaction about meals being served on disposable dishes with disposable utensils because of the broken dishwasher. The finding is: 1) During the dining meal observation of the Breakfast and Lunch meals for all nine resident units on 10/16/2024 and 10/17/2024, the meals were served on disposable Styrofoam plates with disposable utensils. During an interview on 10/16/2024 at 12:45 PM, the Dietary Supervisor stated the residents were receiving their meals on disposable Styrofoam food containers because the dishwashing machine was not working. The Dietary Supervisor did not know how long the dishwashing machine had not been in working condition. During an interview on 10/23/2024 at 3:16 PM, the Administrator stated they were aware of the residents' dissatisfaction with the use of disposable dishes and utensils. The Administrator stated that the dishwashing machine had not been functioning since January of this year (2024). The Administrator stated that the issue has not been addressed since January 2024 due to a combination of failed contractor agreement attempts in January of this year (2024) and the facility's reluctance to provide funds because of a potential facility closure or sale plan earlier this year. 2) During the Resident Council meeting on 10/16/2024 at 2:30 PM, seven of seven residents in attendance verbalized dissatisfaction with utilizing disposable plates and utensils since the beginning of the year due to the facility's broken dishwashing machine. (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 - Some	Resident #267 was admitted with diagnoses including Metabolic encephalopathy, Generalized abdominal pain, and Gastric ulcers. The 9/10/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact. During an interview on 10/16/2024 at 3:48 PM, Resident #267, the resident council president, stated that all meals are being served on disposable plates with disposable utensils because the dishwashing machine had been broken for several months with no indication of when it would be repaired. Resident #267 stated that the facility is aware of the resident's dissatisfaction with meals served on Styrofoam plates and the use of poor-quality plastic utensils. Resident #267 stated that the resident council members have conveyed their desire for regular plates and utensils to the facility Administrator on multiple occasions. Resident #267 stated that using the Styrofoam disposable plates diminishes the experience of a quality meal. Resident #5 was admitted with diagnoses including Chronic Kidney Disease, Hypertension, and Gastro-Esophageal Reflux Disease. The 9/6/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. During an interview on 10/16/2024 at 3:50 PM, Resident #5, a regular attendee of the resident council meetings, stated that Resident Council members have complained to the administrator that the plastic utensils are of poor quality and make it difficult for the residents to enjoy their meals. 10 NYCRR 415.3(d)(1)(i)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024 the facility did not ensure that the interdisciplinary team had determined that self-administration of medications was clinically appropriate for each resident. This was identified for one (Resident #79) of six residents reviewed for Accidents. Specifically, Resident #79 was self-administering the Nasal Moisturizing Spray and the facility staff was aware. A review of the resident's medical records indicated no documented assessment to determine if the resident could safely self-administer the medication and there was no physician's order to self-administer the Nasal Moisturizing Spray. The finding is: The facility's policy and procedure titled Self-Administration of Medication, last revised on 6/3/2024 documented to permit each resident to self-administer medications if the interdisciplinary team has determined that the resident can securely store, safely/accurately administer their medications, and maintain a complete and accurate record of such administration. If a resident is deemed capable of self-administering their medication, the physician will write the orders for medication as self-administration. Resident #79 was admitted with Diagnoses including Paraplegia (loss of muscle function in the lower half of the body), Chronic Obstructive Pulmonary Disease (COPD), and Edema. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #79's Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #79 had intact cognition. Resident #79 received respiratory treatment that included oxygen therapy. A Comprehensive Care Plan (CCP) titled Respiratory Disorders: Nasal Congestion, dated 10/5/2018 and last revised on 1/19/2024 documented interventions that included administering medications and assessing for shortness of breath. Oxygen therapy as per physician's order and provide inhalation or nebulizer treatment. A physician's order dated 10/5/2024 documented Nasal Moisturizing 0.65 percent spray. One drop by nasal route twice a day for Nasal Congestion. During an observation and interview on 10/16/2024 at 10:08 AM, Resident #79 was observed with a bottle of Nasal Moisturizing spray on their overbed table. Resident #79 stated the nurse had left the Nasal Moisturizing spray bottle so they (Resident #79) could self-administer the nasal spray. There was no nurse present in Resident #79's room during the observation. The Medical Record lacked documented evidence of a physician's order and assessment for self-administration of medication. A review of the Electronic Medical Administration Record (EMAR) revealed that the nurses had been signing for the Nasal Moisturizing 0.65 spray at 9:00 AM and 5:00 PM every day. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 10:08 AM, Resident #79 stated they administered the Nasal Moisturizing spray themselves. Resident #79 stated the nurses gave them (Resident #79) the spray bottle to self-administer the medication and they (nurses) took the Nasal Moisturizing spray bottle at the end of the shift to keep it in the medication cart. During an interview on 10/16/2024 at 12:39, Registered Nurse #3, Medication Nurse, stated they had left the nasal spray with Resident #79 to self-administer the medication and then they (Registered Nurse #3) signed the Electronic Medical Administration Record (EMAR). Registered Nurse #3 stated that they typically handed the nasal spray bottle to the resident to self-administer the medication. During an interview on 10/21/2024 at 3:30 PM, Licensed Practical Nurse #6 stated they worked the 3:00 PM-11:00 PM shift, and Resident #79 had always self-administered the nasal saline spray. Licensed Practical Nurse #6 stated they would take the nasal spray from Resident #79 at the end of their shift to store the nasal saline spray in the medication cart. During an interview on 10/22024 at 11:17 AM, the Director of Nursing Services stated the nurses should not have left the saline spray bottle with Resident #79 to self-administer. Resident #79 should have been assessed first for competency in self-administering the medications and the Physician should have been notified to obtain an order to self-administer the nasal saline spray. 10 NYCRR 415.3(f)(1)(vi)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure that each resident was provided a safe, clean, comfortable, and homelike environment. This was identified for one (Unit Seacliff 1) of nine units observed during the environmental task. Specifically, Resident #246 's privacy curtain was ripped and had brown stains. The finding is: The facility's policy for Resident Room Cleaning, dated March 2022, documented meaning and sanitizing to improve sanitation and ensure the highest level of cleanliness throughout the facility. To control cross-contamination, and the spread of bacteria and infection to maintain the outward experience of the facility. Complete high and low dusting of all flat surfaces, wall surfaces, corners and edges, windows, drapery, pictures, and ceiling features. The policy did not include when to change or wash the curtains. The Facility's policy for Resident Room-Homelike Environment, dated 6/21/2024 documented the facility is obligated to provide residents with a safe, home-like environment. Resident #246 had diagnoses that included Polyneuropathy (nerve damage), Type 2 Diabetes Mellitus, and Major Depressive disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. During an environmental tour of Unit Seacliff 1 on 10/16/2024 at 10:25 AM PM, Resident #246's privacy curtain was ripped and had brown stains. During an interview on 10/22/2024 at 10:20 AM, Resident #246 stated the privacy curtain had been ripped and was dirty with brown stains and had never been replaced since they were admitted to the facility. They stated it would be wonderful to have a clean and not ripped privacy curtain. Resident #246 stated the facility staff was aware of the ripped privacy curtain. During an environmental tour of Unit Seacliff 1 on 10/22/2024 at 11:00 AM, Resident #246's privacy curtain was ripped and had brown stains. During an interview on 10/22/2024 at 10:23 AM, Certified Nursing Assistant #5 and Certified Nurse's Assistant #6 both stated they were aware the privacy curtain in Resident #246's room was ripped for a while. They had informed the nurse about the ripped curtain; however, could not recall the name of the nurse. They both stated that the Certified Nursing Assistants do not notify the housekeeping staff about the housekeeping issues including the ripped curtains, they only notify the nurses on the unit, verbally. During an interview on 10/22/2024 at 10:30 AM, Registered Nurse #8 stated they were not aware of the ripped and dirty privacy curtain in Resident #246's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 2:21 PM, Housekeeper Supervisor#1 stated the privacy curtains are replaced for each resident room every three to four weeks. Housekeeper Supervisor #1 stated they did not know Resident #246's privacy curtain was ripped and dirty and they were not notified that the curtain needed to be replaced. 10 NYCRR 415.5(h)(2)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on record review and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure that the Minimum Data Set (MDS) assessment accurately reflects the resident's status. This was identified for one (Resident #262) of 38 sampled residents. Specifically, the Minimum Data Set assessment for Resident #262 did not accurately indicate that the resident was receiving comfort care. The finding is: The facility policy and procedure titled Completion of the RAI Process last reviewed 3/16/2023, documented that assessments will be completed within the guidelines outlined in the Resident Assessment Instrument (RAI) manual, including the care planning processes to lead to the development of a plan of care to address and monitor each resident's needs and function, and to track changes in the resident's status. Staff may utilize information in the medical record to assist with the completion of the Minimum Data Set. Resident #262 was admitted with diagnoses including Alzheimer's disease, Bipolar Disorder, and Diabetes Mellitus. A Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severely impaired cognition. The Minimum Data Set documented comfort care was not provided in the last 14 days. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three, which indicated the resident had severely impaired cognition. The Minimum Data Set documented comfort care was not provided in the last 14 days. A physician's order for Comfort Measures Only (CMO), was first ordered on 2/4/2023 and last renewed on 10/19/2024. A comprehensive care plan titled Advance Directives, effective 3/30/2021 and last reviewed on 9/10/2024, documented that Resident #262 received comfort measures only. A comprehensive care plan titled Comfort Care/Palliative Care/Hospice Care Plan, effective 4/8/2022, last reviewed 9/10/2024, documented interventions including comfort care. During an interview on 10/23/2024 at 1:15 PM, the Minimum Data Set Director stated Resident #262 was placed on comfort care since 2/4/2023 as per the physician's orders. The Minimum Data Set was inaccurately coded as not receiving comfort care in the past 14 days. During an interview on 10/23/2024 at 2:37 PM, the Director of Nursing Services stated the Minimum Data Set Coordinators and Minimum Data Set Director were responsible for ensuring the accuracy of the Minimum Data Set assessment. The Director of Nursing Services further stated the provision of comfort care should have been indicated on the Minimum Data Set assessments for Resident #262. 10 NYCRR 415.11(b)

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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** 44925 Based on record review and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/24/2024, the facility did not ensure that a person-centered Comprehensive Care Plan (CCP) was developed to meet the resident's medical and nursing needs. This was identified for one (Resident #331) of four residents reviewed during the Infection Control Task. Specifically, Resident #331 had a physician's order to place Resident #331 on contact precautions since 5/22/2024. There was no documented evidence that a care plan was developed to reflect Resident #331 was on contact precaution until 10/16/2024. The finding is: The Comprehensive Care Plan Policy dated 2/01/2021 documented that residents of the facility will have a Comprehensive Care Plan completed per Federal and State requirements. An individual Comprehensive Care Plan will be developed for each problem, strength, or need, measurable objectives, and timetables to meet the resident's physical, mental, and psychosocial needs that are identified on the resident's Comprehensive Assessments. The Comprehensive Care Plan is prepared with an interdisciplinary team approach. Resident # 331 had diagnoses including Cerebral Infarction(disrupted blood flow to the brain), Ventilator-dependent, and Tracheostomy Status. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident received Tracheostomy care and Ventilator care. The Minimum Data Set did not indicate the resident had infections in the look-back period. The physician's order dated 5/22/2024 documented Contact Precautions secondary to Pseudomonas {Carbapenem (antibiotic) Resistant} Organisms. A review of the resident's Comprehensive Care Plan from May 2024-10/15/2024 revealed there was no care plan for isolation precautions developed for Resident #331 until 10/16/2024. During an interview on 10/22/2024 at 10:43 AM, Infection Control Nurse#1 stated the resident had been on isolation precautions since May 2024 when they were readmitted to the facility with the drug-resistant Pseudomonas infection. The Infection Control Nurse stated they were responsible for managing the care plans related to infections. The Infection Control Nurse stated they did not develop the care plan for Resident#331's infection and isolation precautions and should have. During an interview on 10/22/2024 at 1:18 PM, the Minimum Data Set Director stated that the unit nurses were responsible for developing and updating the care plans for each resident and it was an oversight that an isolation care plan was not developed for Resident #341. During an interview on 10/22/2024 at 2:34 PM, the Director of Nursing Services stated Resident#331 should have a care plan developed for infection control including contact precautions. 10 NYCRR 415.11(c)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observation, record review, and staff interviews during a recertification survey initiated on 10/16/2024 and completed on 10/24/2024, the facility did not ensure that services provided or arranged by the facility meet the current professional standards of quality. The was identified on one (Woodcrest 2 unit) of nine units observed for medication storage task. Specifically, Licensed Practical Nurse #9 pre-poured medications in a medication cup and stored the medication cup in the medication cart without appropriate labels. Licensed Practical Nurse #9 then attempted to administer the medications to the wrong resident (Resident #100) without properly identifying the resident. The finding is: The Medication administration policy dated 9/07/2023 documented Medication administration will be conducted according to each resident's individualized care plan and physician's orders. Medication administration times will be strictly adhered to, and medications will be administered at the prescribed intervals. Before administering any medication, nursing staff will verify the resident's identity using two patient identifiers (for example name band and date of birth) to ensure the right resident receives the right medication. Nursing home staff will carefully review each medication order for accuracy, including the medication name, dosage, route of administration, and administration time. Medications will be prepared in a clean and designated medication preparation area to prevent cross-contamination. Resident #100 had diagnoses of Parkinson's Disease, Type 2 Diabetes Mellitus, and Essential Tremor. The Minimum Data Set assessment dated [DATE] documented that Resident #100 had a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. Resident #100 had diagnoses of Parkinson's Disease, Type 2 Diabetes Mellitus, and Essential Tremor. The Minimum Data Set assessment dated [DATE] documented that Resident #100 had a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The physician's order dated 10/5/2024 documented Bupropion (antidepressant) 150 milligrams 24-hour tablet extended release 1 tablet by oral route once daily for nicotine dependence and Depression. Buspirone (anti-anxiety) 5 milligrams 1 tablet by oral route two times per day for anxiety disorder. Furosemide (diuretic) 40 milligrams tablet, give 1 tablet by oral route once daily at 9:00 AM daily, and Miralax (stool softener) polyethylene glycol 3350 17 grams/dose oral powder, give 17 grams mixed with 8 ounces of fluid by oral route once daily. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Woodcrest 2 Unit Medication Cart #1 was observed on 10/17/2024 at 9:24 AM with Licensed Practical Nurse #9. There was a medication cup containing two tablets and three capsules stored in the top drawer of the medication cart. The medication cup had 214 written on the cup. Licensed Practical Nurse #9 stated 214 indicated the resident room number. Licensed Practical Nurse #9 stated the medications in the cup had two capsules of Bacid (probiotic), two tablets of Tylenol (pain medication) 325 milligrams, and one capsule of Neurontin (medication for nerve pain) 100 milligrams. While Licensed Practical Nurse #9 was speaking to the Surveyor, Resident #100 approached Licensed Practical Nurse #9 and requested they get their medication. Licensed Practical Nurse #9 took the souffle cup with the pre-poured Neurontin and Bacid capsules and Tylenol tablets and attempted to administer the medications to Resident #100. Resident #100 stated they already received their morning medications and were only requesting to get the Miralax and that they did not reside in room [ROOM NUMBER]. During an interview on 10/17/2024 at 9:35 AM, Licensed Practical Nurse #9 stated they were a float nurse covering for the medication nurse on the Woodcrest 2 unit. Licensed Practical Nurse #9 stated they offered the wrong medications to the wrong resident and realized that Resident #100 was not the correct resident to receive the medications that were stored in the souffle cup; they thought Resident #100 resided in room [ROOM NUMBER], but later realized that Resident #100 was not from room [ROOM NUMBER]. They should have checked the resident's identification band to make sure the medication was being administered to the right resident. Licensed Practical Nurse #9 stated they usually prepare the medications in front of the resident rooms and then administer the medications soon after they prepare them. Today they pre-poured the medications at the nursing station and identified the medication cups with the residents' room numbers. During an interview on 10/22/2024 at 4:18 PM, the Director of Nursing Services stated Licensed Practical Nurse #9 failed to follow the five rights for medication administration policy which were: the Right resident, the right medication, the right time, the right dose, and the right route. The Director of Nursing Services stated that the medications should never be pre-poured and should never be left in the medication cart without identification labels. 10 NYCRR 415.11(c)(3)(i)

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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. 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure a resident with pressure ulcers received the 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 #176) of three residents reviewed for Pressure Ulcers. Specifically, Resident #176 had a physician's order for an alternating air mattress due to multiple pressure ulcers. The resident's most recent weight was 86 pounds. The air mattress weight setting was set to a firm setting which corresponds to a resident who weighs between 360-400 pounds; however, the air mattress was observed to be deflated and was not functioning as intended. The finding is: The facility's policy titled Management of Pressure Ulcers, revised on 2/18/2022, documented that pressure ulcer care requires an interdisciplinary approach that addresses the following areas to promote healing of tissue: reduce or eliminate causative factors such as pressure due to immobility, friction, shear, moisture, and circulatory impairments. Establish an interdisciplinary treatment plan that promotes wound healing and addresses other conditions that may affect wound healing. The alternating air mattress manual, provided by the facility, documented that the soft/firm pressure adjustment knob should be adjusted for a comfortable pressure level customized according to the resident's weight. An illustration in the manual confirms that the soft adjustment corresponds to a resident's weight of 80 pounds and the firm adjustment corresponds to a resident's weight of 400 pounds. Resident #176 was admitted with diagnoses including Non-Alzheimer's Dementia, Malnutrition, and Hip Fracture. The 9/4/2024 Significant Change Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision-making. The Minimum Data Set assessment documented the resident had seven unstageable (the wound depth is not clear because the wound is covered by a layer of dead tissue) pressure ulcers due to coverage by slough/eschar (dead tissue), and nine unstageable pressure ulcers classified as deep tissue injury (damage to the underlying soft tissues caused by pressure). The resident required substantial/maximal assistance for rolling left to right and was dependent on staff for transfers requiring mechanical lift. The most recent resident weight in the medical record, dated 9/23/2024, was 86.1 pounds. Physician's orders, dated 10/6/2024, documented Comfort Measures Only; Ensure all wound sites are off-loaded every shift; Concave Air Mattress; monitor placement, function, and settings of the concave air mattress every shift. A physician's order dated 10/9/2024 documented treatment orders for the right hip unstageable pressure ulcer and to ensure the site is off-loaded at all times. (continued on next page)

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	335555	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Heights Nursing and Rehabilitation Center	378 Syosset Woodbury Road Woodbury, NY 11797

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 10/22/2024 documented treatment orders for the sacral and left hip wound pressure ulcer and to ensure the site is off-loaded at all times, for diagnosis of pressure ulcer of left hip, unstageable. A wound consult written by Nurse Practitioner #1, dated 10/15/2024 documented to ensure the sacrum and right and left hip wound areas are off-loaded at all times. A review of the October 2024 Medication Administration Record revealed nurses were monitoring the placement, function, and settings of the concave air mattress each shift. A review of the October 2024 Treatment Administration Record revealed nurses documented each shift that all wound sites were off-loaded. On 10/16/2024 at 10:22 AM, Resident #176 was observed in bed. The air mattress weight setting pressure control knob was set to firm at 360 pounds. On 10/22/2024 at 11:10 AM, Resident #176 was observed in bed. The air mattress weight setting pressure control knob was set to firm between the 360-pound and 400-pound settings. The resident was lying on their back. During an interview on 10/22/2024 at 11:27 AM, Licensed Practical Nurse #1 (unit nurse, not assigned to Resident #176 today) stated housekeeping is responsible for adjusting the weight setting on the air mattress pump. Licensed Practical Nurse #1 checked the mattress pump setting and confirmed that the air mattress weight setting was set between 360-400 pounds. Licensed Practical Nurse #1 did not attempt to adjust the setting and stated they were unfamiliar with the air mattress pump and had never touched the setting. A review of the October 2024 Medication Administration Record revealed Licensed Practical Nurse #1 had signed for monitoring, placement, function, and setting of the concave air mattress for Resident #176 during the month on multiple occasions. During an observation and interview on 10/22/2024 at 11:46 AM, Housekeeping Director #1 observed and assessed Resident #176's air mattress with the Surveyor and stated the air mattress was deflated, even though the air mattress weight setting was set at the maximum weight. Housekeeping Director #1 stated the air mattress was malfunctioning and would have to be changed. Housekeeping Director #1 stated the weight setting on the air mattress should be set according to the resident's weight. The nurses on the unit should check the mattress weight setting, as well as the mattress itself, and notify housekeeping if the air mattress is malfunctioning. During an interview on 10/22/2024 at 1:47 PM, Certified Nursing Assistant #1 stated they make sure the air mattress pump light is on and they also check to see if the mattress is firm, but they do not check the weight setting. Certified Nursing Assistant #1 stated the air mattress was firm when they checked right before they went to lunch today. During an interview on 10/22/2024 at 1:52 PM, Licensed Practical Nurse #3 (assigned to Resident #176) stated they do not check the weight setting on the air mattresses. They just check to see if the mattress is firm. Licensed Practical Nurse #3 stated the mattress was fine today when they did the medication pass administration at 9:00 AM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the October 2024 Medication Administration Record revealed Licensed Practical Nurse #3 had documented for monitoring, placement, function, and settings of concave air mattress for Resident #176 during the month on multiple occasions, including for 10/22/2024. During an interview on 10/22/2024 at 2:13 PM, Licensed Practical Nurse #4 (wound care nurse) stated the weight setting on the air mattress should be consistent with the resident's weight, and the nurses on the unit should check the air mattress weight setting during daily care because it is not uncommon for the air mattresses to malfunction. Licensed Practical Nurse #4 stated they did wound rounds today (10/22/2024) with the Nurse Practitioner, but did not check the air mattress setting for Resident #176 today due to an oversight. During an interview on 10/22/2024 at 2:34 PM, Nurse Practitioner #1 stated the weight setting on the air mattress should be consistent with resident weight because that helps with offloading and pressure relief. During an interview on 10/23/2024 at 9:26 AM, the Director of Nursing Services stated the unit nurses are supposed to check that the air mattress is functioning, is inflated properly, and the setting on the pump is appropriate each shift. The unit nurses should immediately report to the unit supervisor or the housekeeping staff if the setting on the pump is not accurate. The unit nurses do not change the setting. 10 NYCRR 415.12(c)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49245 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure that each resident's environment remained as free of accident hazards as possible. This was identified for one (Resident #243) of six residents reviewed for Accident Hazards. Specifically, Resident #243's room was observed with an unsecured, free-standing oxygen E-Cylinder tank (the most common and largest portable oxygen tank) next to the resident's bed. The E-Cylinder tank was not secured in a rolling cylinder stand as per the facility's policy. The finding is: The facility policy and procedure titled Oxygen safety, last revised on 5/4/2024 documented that safety is the responsibility of all staff, residents, visitors, and the public. Hazards or other conditions that could develop into a hazard must be reported to a supervisor or Maintenance Director as soon as practical. Anyone may report a hazard or potential hazard. When small-size (A, B, D, or E) cylinders are in use, they shall be attached to a cylinder stand or medical equipment designed to receive and hold compressed gas cylinders. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. Protect cylinders from damage by not storing them in locations where heavy objects may strike or fall on them, or where they can be tipped over by foot traffic or door movement. Resident #243 was admitted with Diagnoses of Alzheimer's, Diabetes, and Acute Cough. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #243 had severe cognitive impairment. The Minimum Data Set (MDS) documented that Resident #243 did not receive any Respiratory Therapy. Resident #243's Physician's Order dated 5/1/2024 documented DuoNeb 2.5 milligrams-0.5 milligrams per 3 milliliters solution for nebulization. Inhale 3 milliliters by nebulization route 3 times per day for Acute Cough. The order was discontinued on 9/11/2024. There were no documented Physician's Orders for the Oxygen use for Resident #243. A Comprehensive Care Plan (CCP) dated 6/15/2024 titled, Acute Cough, documented interventions that included nebulization treatment, medication as per Physician's Orders, and evaluation for shortness of breath, chest pain, and discomfort with breathing or coughing. During an observation on 10/16/2024 at 1:29 PM, a free-standing, unsecured E-cylinder oxygen tank was observed next to Resident #243's bed. The gauge needle of the E-cylinder oxygen tank was at 1,000 pounds per square inch (PSI, defined as the unit of measurement used to indicate the amount of oxygen in a tank or cylinder), which indicated that the oxygen tank was half full. A nebulizer mask and tubing were attached to the E-cylinder oxygen tank delivery port. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/16/2024 at 1:14 PM, Licensed Practical Nurse #5 stated Resident #243 used the oxygen tank for nebulization. Licensed Practical Nurse #5 stated they did not notice the E-Cylinder oxygen tank was still in Resident #243's room and was not secured in the rolling cylinder stand. Licensed Practical Nurse #5 stated all oxygen tanks must be secured in a rolling cylinder stand. During an interview on 10/21/2024 at 2:31 PM, Certified Nursing Assistant #2 stated they worked on the evening shift and did not notice the free-standing, unsecured E-Cylinder oxygen tank in Resident #243's room. Certified Nursing Assistant #2 stated they would have reported to the Nurse if they had seen the unsecured tank in Resident #243's room. During an interview on 10/21/2024 at 2:44 PM, Registered Nurse #3 stated that Resident #243 had an order for nebulization, and they had used the E-Cylinder oxygen tank for nebulization because they did not have a nebulizer machine at that time. Registered Nurse #3 stated that the physician's order for nebulization had been discontinued in September 2024. Registered Nurse #3 stated the E-Cylinder oxygen tank should have been taken out of Resident #243's room. Registered Nurse #3 stated they did not know the E-Cylinder oxygen tank remained unsecured in Resident #243's room. During an interview on 10/22/2024 at 8:46 AM, the Director of Plant Operation stated that all E-Cylinder oxygen tanks should be secured in a rolling cylinder stand. The Director of Plant Operation stated there should not be any oxygen tanks freely standing and unsecured. The Director of Plant Operation stated that oxygen tanks are combustible (able to catch fire and burn easily) and should not be dragged nor bounced on the floor due to static that can cause combustion. The Director of Plant Operation stated that an unsecured oxygen tank can fall, rupture, and cause physical damage because the tank is highly pressurized. During an interview on 10/22/2024 at 9:44 AM, the Director of Nursing Services stated there should not be any unsecured oxygen tanks in the unit. The nurses should not have used the E-Cylinder oxygen tank for nebulization because the facility had plenty of nebulizer machines. 10 NYCRR 415.12(h)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure a system of records and accounts of all controlled drugs were maintained, and the facility did not ensure that services provided or arranged by the facility meet the current professional standards of quality. This was identified for three (Resident #207, Resident #301, and Resident #340) of three residents reviewed during the medication storage task and 2) one (Woodcrest 2 Unit) of nine units observed during the medication storage task. Specifically, 1) Resident #207 and Resident #301 Controlled Substance Disposition Record were not accurately reconciled after the medications were administered to the residents. -A Blister Pack containing 12 Marinol 10 milligram capsules (Scheduled III drug) was observed stored in the locked box in the medication refrigerator; however, there was no Controlled Substance Disposition Record maintained for the medication. 2) During an observation on the Woodcrest 2 Unit, pre-poured medications (three capsules and two tablets) were observed in a medication cup stored in the medication cart. Licensed Practical Nurse #9 was observed attempting to administer the pre-poured medications to the wrong resident. The findings are: 1) Resident #207 was admitted with diagnoses that included Multiple Sclerosis and Chronic Obstructive Pulmonary Disease. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented the resident received Opioids during the last seven days. Resident #207's physician order dated 9/28/2024 documented Oxycontin 10 milligram crush resistance, extended release, give 1 tablet by oral route every 12 hours for chronic pain. Resident #207's Medication Administration Record documented Oxycontin 10 milligrams was administered at the scheduled time of 9:00 AM on 10/22/2024. During a Medication Storage Task observation on 10/22/2024 at 10:55 AM on the [NAME] 2 Nursing Unit, Resident #207's Controlled Substance Disposition Record for Oxycontin (a narcotic medication) 10 milligrams documented that the last tablet was used on 10/21/2024 at 9:00 PM with 21 remaining tablets; however, the blister pack for the Oxycontin 10 milligram revealed there were only 20 tablets available. The Controlled Substance Disposition Record was not updated after the medication was administered to the resident on 10/22/2024 at 9:00 AM. Resident #301 was admitted with diagnoses that included Parkinson's Disease and Polyneuropathy. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set assessment documented the resident received Opioids during the last 7 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #301's physician order dated 9/27/2024 documented Tramadol extended-release 100 milligrams, give 1 tablet by oral route once daily for pain. Resident #301's Medication Administration Record dated 10/2024 documented Tramadol extended release 100 milligrams, was administered at the scheduled time of 9:00 AM on 10/22/2024. During a Medication Storage Task observation on 10/22/2024 at 10:51 AM on the [NAME] 2 Nursing Unit, Resident #301's Controlled Substance Disposition Record for Tramadol (pain medication-controlled substance) Extended Release 100 milligrams documented that the last tablet was used on 10/21/2024 at 9:15 AM with eight remaining tablets; however, the blister pack for the Tramadol Extended Release 100 milligram only had seven tablets available. The Controlled Substance Disposition Record was not updated after the medication was administered to the resident on 10/22/2024 at 9:00 AM. -Resident #340 was admitted with diagnoses that included Cachexia (muscle loss) and Dysphagia (difficulty swallowing). The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status was 13, which indicated the resident had intact cognition. The Minimum Data Set documented the resident did not receive scheduled pain medication. Resident #340's physician order dated 6/9/2024 documented to discontinue Dronabinol (Marinol) 10 milligrams by oral route once daily. During a Medication Storage Task observation on 10/22/2024 at 10:58 AM on the [NAME] 2 Nursing Unit, a Blister Pack containing 12 Marinol 10 milligram capsules (Scheduled III drug) was observed stored in the locked box in the medication refrigerator. There was no Controlled Substance Disposition Record to indicate an account of the controlled drug was maintained and periodically reconciled for the past six months. The Controlled Substance Disposition Record provided by the facility documented the last entry on 4/4/2024 indicating 12 capsules were remaining. During an interview on 10/22/2024 at 11:15 AM, Licensed Practical Nurse #8 stated they had administered the Oxycontin and the Tramadol to the residents at 9:00 AM today, but did not sign the Controlled Substance Disposition Record. Licensed Practical Nurse #8 stated they had a bad habit of not signing the Controlled Substance Disposition Record and that it was their mistake that they were rushing. Licensed Practical Nurse #8 stated they should have reconciled and signed the Controlled Substance Disposition Record as soon as they had removed the tablets from the Blister Packs. Licensed Practical Nurse #8 stated they did not count the Marinol because they were not aware the medication was in the locked box stored in the refrigerator. Licensed Practical Nurse #8 stated they did not know the procedure to store the discontinued controlled medication. During an interview on 10/22/2024 at 11:57 AM, Registered Nurse #7 stated that Licensed Practical Nurse #8 should have reconciled the narcotics at the time they removed the tablets from the Blister Packs to ensure the accuracy of the narcotic count. Registered Nurse #7 stated that the nurses were inserviced on the proper process for reconciling controlled drugs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 3:47 PM, the Director of Nursing Services stated when the nurses remove the narcotics from the blister pack, they must sign the Controlled Substance Disposition Record immediately, then sign the Medication Administration Record after administration of the medication. The Director of Nursing Services stated that Licensed Practical Nurse #8 should have reconciled and signed the Controlled Substance Disposition Record at the time they removed the Medications (Oxycontin and Tramadol) from the Blister Packs. During a subsequent interview on 10/22/2024 at 4:01 PM, the Director of Nursing Services stated when a narcotic medication is discontinued, the nurses on the unit were responsible for providing the Controlled Substance Disposition Record and the Blister Pack to their Supervisor who would then bring both the Controlled Substance Disposition Record and the Blister Pack to the Director of Nursing Services. The Director of Nursing Services stated they and the Supervisor would reconcile the medication to ensure the accuracy of the medication on the Controlled Substance Disposition Record and the number of medications in the Blister Pack. The Director of Nursing Services stated they were not aware that Marinol was discontinued for Resident #340 as they did not receive the Controlled Substance Disposition Record or the Blister Pack from the unit. 44925 2) The Medication administration policy dated 9/07/2023 documented that medication administration will be conducted according to each resident's individualized care plan and physician's orders. Before administering any medication, nursing staff will verify the resident's identity using two patient identifiers (e.g., name band and date of birth) to ensure the right resident receives the right medication. Nursing home staff will carefully review each medication order for accuracy, including the medication name, dosage, route of administration, and administration time. Medications will be prepared in a clean and designated medication preparation area to prevent cross-contamination. Resident #100 had diagnoses of Parkinson's Disease, Type 2 Diabetes Mellitus, and Essential Tremor. The Minimum Data Set assessment dated [DATE] documented that Resident #100 had a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The physician's order dated 10/5/2024 documented Bupropion (antidepressant) 150 milligrams 24-hour tablet extended release 1 tablet by oral route once daily for nicotine dependence and Depression. Buspirone (anti-anxiety) 5 milligrams 1 tablet by oral route two times per day for anxiety disorder. Furosemide (diuretic) 40 milligrams tablet, give 1 tablet by oral route once daily at 9:00 AM daily, and Miralax (stool softener) polyethylene glycol 3350 17 grams/dose oral powder, give 17 grams mixed with 8 ounces of fluid by oral route once daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Woodcrest 2 Unit Medication Cart #1 was observed on 10/17/2024 at 9:24 AM with Licensed Practical Nurse #9. There was a medication cup containing two tablets and three capsules stored in the top drawer of the medication cart. The medication cup had 214 written on the cup. Licensed Practical Nurse #9 stated 214 indicated the resident room number. Licensed Practical Nurse #9 stated the medications in the cup had two capsules of Bacid (probiotic), two tablets of Tylenol (pain medication) 325 milligrams, and one capsule of Neurontin (medication for nerve pain) 100 milligrams. While Licensed Practical Nurse #9 was speaking to the Surveyor, Resident #100 approached Licensed Practical Nurse #9 and requested they get their medication. Licensed Practical Nurse #9 took the souffle cup with the pre-poured Neurontin and Bacid capsules and Tylenol tablets and attempted to administer the medications to Resident #100. Resident #100 stated they already received their morning medications and were only requesting to get the Miralax and that they did not reside in room [ROOM NUMBER]. During an interview on 10/17/2024 at 9:35 AM, Licensed Practical Nurse #9 stated they were a float nurse covering for the medication nurse on the Woodcrest 2 Unit. Licensed Practical Nurse #9 stated they offered the wrong medications to the wrong resident and realized that Resident #100 was not the correct resident to receive the medications that were stored in the souffle cup; they thought Resident #100 resided in room [ROOM NUMBER], but later realized that Resident #100 was not from room [ROOM NUMBER]. They should have checked the resident's identification band to make sure the medication was being administered to the right resident. Licensed Practical Nurse #9 stated they usually prepare the medications in front of the resident rooms and then administer the medications soon after they prepare them. Today they pre-poured the medications at the nursing station and identified the medication cups with the residents' room numbers. During an interview on 10/17/2024 at 9:43 AM, Registered Nurse Supervisor #9 stated that Licensed Practical Nurses should administer the medications immediately after preparing the medications in the medication cup. Before administering the medications, they must check the resident's name and the medication blister pack to ensure the right medication is being administered to the right resident. During an interview on 10/22/2024 at 4:18 PM, the Director of Nursing Services stated Licensed Practical Nurse #9 failed to follow the five rights for medication administration policy which were: the Right resident, the right medication, the right time, the right dose, and the right route. The Director of Nursing Services stated that the medications should never be pre-poured and should never be left in the medication cart without proper identification labels. 10 NYCRR 415.18(a)

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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** 28670 Based on observations, record review, and interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure all drugs and biologicals used in the facility were maintained and stored under proper temperature control. This was identified during a Medication Storage and Labeling Task on one ([NAME] 2 Unit) of nine Nursing Units observed. Specifically, [NAME] 2 Nursing Unit medication refrigerator temperature was observed to be at 60 degrees Fahrenheit. There were two unused/unopened Insulin injection pens and a box of Trulicity (used for Diabetes) injection pens observed stored in the medication refrigerator. Both unopened medications were supposed to be stored in the refrigerator at a temperature between 36 degrees Fahrenheit to 46 degrees Fahrenheit as per the manufacturer's recommendations. The finding is: The facility's Storage of Medication Requiring Refrigeration policy and procedure revised on 7/24/2024 documented that the facility will ensure all medications and biologicals will be stored at proper temperature controls. The refrigerator used for the storage of medications and biologicals includes an accurate functioning thermometer, temperature should be maintained between 36-46 degrees Fahrenheit and the refrigerator temperature is to be monitored every shift to ensure proper temperature control. During a tour of the [NAME] 2 Unit, with Charge Registered Nurse #6 on 10/22/2024 at 11:25 AM, the unit's medication refrigerator was observed with two Insulin injection pens and a box containing Trulicity injection pens. The medication refrigerator temperature was observed to be at 60 degrees Fahrenheit. During an interview on 10/22/2024 at 11:30 AM, Registered Nurse #6 stated they did not know if the temperature for the medication refrigerator was checked on the morning of 10/22/2024. Registered Nurse #6 stated that the temperature of the medication refrigerator is checked daily by the medication nurse and documented on the log sheet. Registered Nurse #6 stated they could not find the daily temperature log sheet for the medication refrigerator. Registered Nurse #6 stated that they did not know the acceptable temperature range for the medication refrigerator or the temperature range for storage of the Insulin and Trulicity pen. During an interview on 10/22/2024 at 3:47 PM, the Director of Nursing Services stated the temperature of the medication refrigerator should be checked daily on every shift by the nurses on the unit. The Director of Nursing Services stated the nurse who counted the narcotics on 10/22/2024, was responsible for checking the temperature of the medication refrigerator. The Director of Nursing Services stated if there was a problem with the thermometer or the refrigerator, the nurses were responsible for reporting to the Maintenance Department for timely follow-up. 10 NYCRR 415.18(e)(1-4)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Heights Nursing and Rehabilitation Center	378 Syosset Woodbury Road Woodbury, NY 11797

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 34798 Based on record review and staff interviews during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure laboratory services were obtained in a timely fashion to meet the needs of each resident. This was identified for one (Resident #108) of five residents reviewed for Unnecessary Medications. Specifically, a Lipid Profile (a blood test to determine different types of fat in the blood) was ordered for Resident #108 in response to a pharmacist medication regimen review. The blood test was ordered in the electronic medical record on 9/27/2024 and 10/11/2024 but was not communicated to the laboratory and therefore was not done. The finding is: The facility's policy titled Diagnostic Tests and Results, dated 3/22/2022 documented it is the policy of the facility to identify diagnostic tests and results that are needed for the management of resident's care and delineate the timeframe in which the tests and results are expected to be performed or available. Further, the facility will ensure that the results of these tests are communicated to the treating provider in a manner that is timely, accurate, complete, and understood by the recipient. The facility will continuously measure, assess, and, if needed, take action to improve its performance with respect to the above as part of its Quality Assurance and Performance Improvement initiative. Resident #108 was admitted with diagnoses including Non-Alzheimer's Dementia, Diabetes Mellitus, and Depression. The 8/29/2024 Annual Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision making. A physician's order dated 6/26/2024 documented Quetiapine (an antipsychotic medication) 50 milligrams tablet; give 1 tablet by oral route once daily at bedtime for diagnosis of Major Depressive Disorder and Unspecified Psychosis. A Medication Regimen Review dated 9/23/2024 documented the resident is currently receiving Quetiapine (Seroquel). Unable to locate recent hemoglobin A1C (a blood test that measures a person's average blood sugar level over the past 2-3 months) and Lipid Profile in the chart. Recommend three months after the start of medication and then annually thereafter. The Physician/Prescriber responded Agree/Will Do on 9/27/2024. A physician's order dated 10/11/2024 ordered the following blood tests: Complete Blood Count (measures the number of cells in your blood), Comprehensive Metabolic Panel (measures chemical balance and metabolism), hemoglobin A1C, Lipid Profile, and Thyroid Stimulating Hormone (measures level of thyroid-stimulating hormone in your body) to be collected on 10/11/2024. A review of the medical record revealed there were blood test results from blood collected on 10/11/2024 for Complete Blood Count, Comprehensive Metabolic Panel, hemoglobin A1C, and Thyroid Stimulating Hormone. There were no results for the Lipid Profile. During an interview on 10/22/2024 at 8:37 AM, Laboratory Representative #1 stated there were no laboratory work results for a lipid profile and did not even see an order for a lipid profile. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 8:54 AM, Physician #1 stated they just started working in the facility on 10/10/2024 and could not explain why the Lipid Profile was not done. Physician #1 stated the lipid profile bloodwork should have been done if it was ordered. During an interview on 10/22/2024 at 9:54 AM, Registered Nurse #1 (unit supervisor) stated there is a two-step system when ordering lab work. First, the order has to be entered into the electronic medical record, and then the laboratory has to be notified through a separate ordering system not related to the resident's medical record. Registered Nurse #1 stated usually, if a resident is prescribed an antipsychotic medication, due to the risk of dyslipidemia (abnormal lipid profile), there should be a lipid profile completed within three months from when the medication was started and then annually thereafter. There is no explanation as to why the lipid profile was not done as ordered on 10/11/2024. During an interview on 10/23/2024 at 9:22 AM, the Director of Nursing Services stated the residents' electronic medical record is not interfaced with the laboratory. All of the laboratory work that was ordered on 10/11/2024 should have been done and the facility will have to speak to the laboratory to determine why the lipid profile was not done. During an interview on 10/23/2024 at 11:25 AM, Registered Nurse #4 (overnight supervisor who entered order on 10/11/2024) stated the laboratory work for the lipid profile should have been drawn, but they did not know why the lipid profile was not done. 10 NYCRR 415.20

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45349 Based on observation, interviews, and record review, during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility failed to ensure that food was served in accordance with professional standards for food service safety. This was identified for one unit (Woodcrest one) of nine units observed during the Dining Facility Task. Specifically, the facility did not monitor the temperature of cold food items served to residents in the Woodcrest One Unit during a lunch meal observation on 10/16/2024. The cold food temperature served during the lunch meal measured between 50-60 degrees Fahrenheit (normal range: below 41 degrees Fahrenheit). The finding is: An undated facility policy and procedure titled Food Temperatures documented that the temperatures of the food items will be taken and properly recorded for each meal. All cold food items must be maintained and served at a temperature of 41 degrees Fahrenheit or below. Temperatures should be taken periodically to ensure cold foods stay below 41 degrees Fahrenheit during the portioning, transporting, and delivery process until received by the individual recipient. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. Food sent to the units for distribution (such as meals) is transported and delivered with maintained temperatures at or below 41 degrees Fahrenheit for cold foods. During a lunch meal observation at the Woodcrest One unit on 10/16/2024 at 12:58 PM, the cold food temperature was not documented on the temperature log. Dietary Aide #1 was observed serving the meal without taking the temperature of the cold food items (such as sandwiches, yogurt, and pudding). Dietary Aide #1 was immediately interviewed and stated they do not take cold food temperatures, they only take the temperature of the hot food items on the steam table. The cold food items were already placed on the individual resident trays in the kitchen prior to the trays being delivered to the unit. On 10/16/2024 at 1:06 PM, Registered Dietitian #1 took the temperature of the following cold food items: the cheese sandwich was measured at 60.7 degrees Fahrenheit, and the chocolate pudding was measured at 50 degrees Fahrenheit. Registered Dietitian #1 stated that these temperatures were not in compliance with food safety standards. During an interview on 10/23/2024 at 10:53 AM, the Food Service Director stated that the food temperatures of hot and cold food items should be measured by the dietary staff prior to meal services. The Food Service Director stated it is important to take the temperatures to ensure that the food is not in the danger zone (The temperature danger zone for food is between 40 F and 140 F, where bacteria can grow rapidly) where there is an increased risk of illness. The Food Service Director stated the cold food should have gone to the unit in bulk on a pan of ice rather than pre-plated on the individual trays. 10 NYCRR 415.14(h)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observations, interviews, and record review during a Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not ensure that medical records were maintained for each resident that were complete and accurately documented in accordance with accepted professional standards of practice. This was identified for one (Resident #184) of one resident reviewed for Respiratory Care. Specifically, Resident #184 was observed receiving oxygen therapy via a nasal cannula on 10/16/2024, 10/17/2024, and 10/21/2024 as per their Physician's order; however, there was no documented evidence that the resident was administered oxygen therapy on 10/16/2024, 10/17/2024, and 10/21/2024. The finding is: The facility policy titled Medication and Treatment Administration Record dated 4/2008 and last revised 5/2023 documented unit licensed nurses are provided with a resident medication profile to ensure medications and treatments are given as ordered. The licensed nurses must adhere to policy and procedure for medication/treatment administration and ensure that medication and treatments are signed for immediately after administration. As needed medications and treatments require documentation on the Medication Administration Record or Treatment Administration Record with time and initial and a nurse's note on the Medication Administration Record or Treatment Administration Record indicating reason for administration. Resident #184 was admitted with diagnoses including Sepsis, and Pneumonia. The Significant Change in Status Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 7, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident did not receive oxygen therapy during the assessment period. A physician's order dated 9/9/2024 and discontinued on 10/21/2024 documented to administer oxygen therapy via a nasal cannula at 1 to 2 liters per minute as needed for Elevated [NAME] Blood Cell Count. Resident #184 was observed on 10/16/2024 at 11:03 AM lying in bed and receiving oxygen therapy from a wall-mounted oxygen flow meter via a nasal cannula at 1.5 liters per minute. A subsequent observation was completed on 10/17/2024 at 9:55 AM. Resident #184 was observed resting in bed and receiving oxygen therapy from a wall-mounted oxygen flow meter via a nasal cannula at 1.5 liters per minute. During an additional observation on 10/21/2024 at 10:42 AM, Resident #184 was observed in bed receiving oxygen from a wall-mounted oxygen flow meter via a nasal cannula at a rate of 1.5 liters per minute. The Treatment Administration Record for October 2024 lacked documented evidence that the resident was administered oxygen therapy from 10/1/2024 to 10/21/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/21/2024 at 10:47 AM, Licensed Practical Nurse #7, the day shift medication nurse, stated Resident #184 had a physician's order for oxygen therapy. Licensed Practical Nurse #7 stated they were unsure why they did not sign the Treatment Administration Record on 10/21/2024 to indicate oxygen administration. Licensed Practical Nurse #7 stated they should have signed for the administration of oxygen therapy on the Treatment Administration Record on 10/21/2024. During an interview on 10/21/2024 at 10:58 AM, Registered Nurse #6, the charge nurse, stated the medication nurses were responsible for administering oxygen as per the physician's orders. The medication nurses are then expected to document oxygen administration on the Treatment Administration Record. Resident #184's Treatment Administration Record should have documented that they received supplemental oxygen on 10/16/2024, 10/17/2024, and 10/21/2024. During an interview on 10/23/2024 at 12:00 PM, the Director of Nursing Services stated nursing staff should have documented on the Treatment Administration Record whenever supplemental oxygen therapy was administered for Resident #184. 10 NYCRR 415.22(a)(1-4)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 45349 Based on observation, interviews, and record review during the Recertification Survey initiated on 10/16/2024 and completed on 10/23/2024, the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. This was identified during the Kitchen Task. Specifically, during a kitchen tour with the Food Production Manager on 10/16/2024 the mechanical dishwashing machine was not in working order. Record review and interviews indicated that the dishwashing machine has been out of order since January 2024. The finding is: A facility policy and procedure dated 4/20/2023 titled Dishwashing, documented the Nutritional Services Department shall maintain a file of written procedures for cleaning and maintaining all equipment in the department. The Dietary Aide will report to the Food Production Manager, Supervisor, or Director of Dietary any problems with the dishwashing machine. Upon receipt of the report of problems with the machine, the Plant Operations is called and a routine work request is prepared. The Plant Operations supervisor will determine whether the problem can be handled internally or if an outside company is required. If the machine requires outside service, the Dietary Supervisor, Production Manager, or Director of Dietary will place a service call. An email dated 1/25/2024 from the former Food Service Director to the equipment repair company documented that a quote for the dishwashing machine repair was received in December 2023. The email documented that approval was received from the facility administration. A follow-up email dated 3/25/2024 documented that there was a delay in receiving the necessary parts for repair. During an interview on 10/18/2024 at 9:25 AM, the Food Service Director stated that they started their employment at the facility approximately four months ago. They stated that during that time, they have had various vendors coming to the facility to provide proposals for the new dishwashing equipment. The food service director further stated that they provided the administrator with the proposal. Last week a plumber was in the facility to review the work needed to be done before the purchase and installation of new equipment. A record review revealed a quote for new equipment dated 9/27/2024. During the kitchen tour with the Food Service Director on 10/18/2024 at 9:27 AM, the inoperable dishwashing machine was observed. During a re-interview on 10/23/2024 at 10:53 AM, the Food Service Director stated they are not aware of the details of the previous conversations. They further stated that they had given the administration recommendations for a new dishwashing machine. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/2024 at 3:16 PM, the Administrator stated the facility has been looking into repairing or obtaining a new dishwashing machine since January 2024. The Administrator stated that the dishwashing machine has been inoperable since the beginning of the year (January 2024). At that time (January 2024), the facility received a repair quote which was approved; however, there was a delay in receiving the necessary parts. They further stated that sometime in March 2024, the former Food Service Director resigned and the facility's ownership was reluctant to commit the necessary funds to purchase or repair the equipment due to the pending plans for the facility closure or sale earlier in 2024. 10 NYCRR 415.5(e)(1)(2)