STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335802	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Arden Inc	46 Harriman Drive Goshen, NY 10924

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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. 40686 Based on observation, interview, and record review conducted during the recertification survey from 6/25/2024 to 7/2/2024, the facility did not ensure each resident was treated with respect and dignity. This was evident for 2 (Resident #13 and Resident #37) of 18 sampled residents during dining observation. Specifically, Resident #37 and Resident #13 were not served lunch at the same time as their tablemates. The findings are: The facility policy titled Open Dining dated 2/16/2007 documented residents participating in open-style dining will be able to dine at their preferred time and are served their meal according to the dining program. On 6/25/2024 at 12:05 PM, Resident #37 and Resident #10 were observed in the dining room seated at the same table. Resident #10 received their meal tray and began eating their lunch. Resident #37 watched their tablemate eat lunch and asked a staff member for a lunch tray. Resident #37 was served their lunch tray at 12:14 PM. On 06/27/2024 at 12:35 PM, Resident #13, #8, #36, and #10 were observed in the dining room seated at the same table. Resident #8, #36, and #10 were served their meal trays and began eating lunch. Resident #13 watched their tablemates eat while other residents in the dining room were served. Resident #13 commented they had not received their lunch and had no food to eat yet. At 12:43 PM, Resident #13 was served their lunch tray. Residents #37 and #13 were not served lunch in a dignified manner to ensure they could begin eating at the same time as their tablemates. On 07/02/2024 at 10:02 AM, the Food Service Director was interviewed and stated the nursing staff were responsible for seating the residents in the dining room in accordance with resident choice and ability to socialize. The [NAME] or nursing staff arrange the meal tickets on the trays according to the posted seating chart to ensure residents were served consistent with their tablemates. The consistency of meal tray service was affected when agency or temporary nursing staff in the dining room were unfamiliar with the residents. (continued on next page)

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	On 07/02/2024 at 10:36 AM, the Director of Nursing was interviewed and stated they devised the dining room table seating chart along with the Director of Activities. The seating chart was revised a few months prior and changed when the facility received new admissions or a resident's tablemate preference changed. Nursing staff were aware of seating changes and, therefore, was responsible for setting up the tray tickets in preparation for meal service. The nursing staff usually know the residents and where they sit. It is difficult to serve Resident #13 and their tablemates simultaneously because some of the residents have physical therapy sessions and arrive to the dining room later. The Director of Nursing was not aware of inconsistencies with meal tray service amongst residents and their tablemates. The nursing staff direct the dietary staff to ensure residents and their tablemates were served simultaneously. 10 NYCRR 415.3(d)(1)(i)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686 Based on observation, interview, and record review conducted during the recertification survey from 6/25/2024 to 7/2/2024, the facility did not ensure residents' right to a safe, clean, comfortable and homelike environment. This was evident during environmental observation of resident Unit 1 and Unit 2. Specifically, 1) Unit 1 was observed with a ceiling leak, stained and uneven carpeting, and stained ceiling tiles, and 2) Unit 2 was observed with broken bathroom floor tiles, stained, frayed, and uneven carpeting, and a broken desk in the nourishment station. The findings are: The facility policy titled Safety Committee Policy dated 4/21/2024 documented the Safety Committee was responsible for identifying issues pertaining to the environment and managing safety, and hazardous materials and wastes. 1) On 06/25/2024 from 9:47 AM to 11:00 AM, 6/26/2024 from 9:30 AM to 5:00 PM, and 6/27/2024 from 9:30 AM to 5:00 PM, Unit 1 was observed with the following: - hallway carpeting with large brown stains and rippled buckling areas causing uneven flooring throughout the unit, - water leaking from the ceiling in the hallway near the dayroom, - stained ceiling tiles in the dayroom. 2) On 6/25/2024 from 9:23 AM to 11:25 AM, 6/26/2024 from 9:30 AM to 5:00 PM, and 6/27/2024 from 9:30 AM to 5:00 PM, Unit 2 was observed with the following: - the nourishment area contained a metal office desk with the handle missing from 1 of 3 drawers on the left side and packing tape wrapped around the broken bottom drawer on the right side, - room [ROOM NUMBER] had 2 holes, measuring 1 and 2 inches respectively, in the bathroom wall directly behind the door, - unit bathroom near room [ROOM NUMBER] with a large linear black stain (approximately 2 feet across) on the floor and cracked, bubbled pieces of linoleum flooring, - large circular black and brown stained and frayed carpeting with several rippled and buckling areas causing uneven flooring throughout the unit (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/2024 at 4:00 PM, the Director of Environmental Services was interviewed and stated the leak in the Unit 1 hallway was caused by a rainstorm from approximately 3 days ago. A roof repair company was retained by the facility to repair the leak. The Director of Environmental Services stated they were planning on repairing and replacing the stained ceiling tiles. The carpeting throughout the facility was installed in 1995 when the facility building was originally constructed. This contributed to the carpet stains and rippling/buckling effect. On 07/02/2024 at 10:45 AM, the Administrator was interviewed and stated ongoing negotiations for another nonprofit owner to acquire the facility has caused renovation and repair delays. The carpeting was shampooed but replacement of the carpeting has not been approved by the current facility owners. The bathroom floors were included in plans to renovate the entire building. The Unit 1 ceiling leak occurred sporadically after rainstorms. The facility hired a roof repair company. The Administrator was unaware of the metal office desk in the nourishment area with broken drawers. The Maintenance Department had a log book where staff documented their requests for repairs. The Environmental Services Director checked the logbook daily. The Administrator stated they also conducted environmental rounds of the facility when on site and communicated any observation concerns to the Director of Environmental Services. 10 NYCRR 415.29

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39308 Based on record review and interview conducted during a recertification survey, the facility did not electronically transmit encoded and completed Minimum Data Set; a federally-mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes) to the Centers for Medicare and Medicaid Services system information within 14 days of the final Minimum Data Set Assessment completion date as required for payment information and quality measure purposes. This was evident for 2 of 2 residents (#16 and #18) reviewed for resident assessment. The findings are: Review of the facility's MDS assessment data completion and submission activities revealed that the following Minimum Data Set records exceeded 120 days from the date of completion and had not been submitted to the Centers of Medicare and Medicaid Services System Information until - Resident # 16: Discharge Minimum Data Set Assessment assessment dated [DATE] was rejected on 3/31/24 and had not been resubmitted until 6/25/24. -Resident # 18: Discharge Minimum Data Set Assessment assessment dated [DATE] was rejected on 3/31/24 and had not been resubmitted until 6/25/24. During interview on 7/1/24 at 4:45 PM the Registered Nurse Minimum Data Set Specialist stated they usually ran reports to ensure all Minimum Data Set Assessments were accepted by Centers for Medicare and Medicaid Services, but had not run the report for the above Minimum Data Set Assessments until 6/25/24. The Registered Nurse Minimum Data Set Specialist stated when the report was run they noted that the 2 assessments had been rejected due to information in section A. NY [NAME] 415.11

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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 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. 39308 Based on record review, observation and interview conducted during a recertification survey, the facility did not develop and implement a person-centered care plan with measurable objectives and time frames in accordance with comprehensive assessments for one of one resident reviewed for Communication-Sensory and Incontinence and one of three residents reviewed for Positioning / Mobility (R #10). Specifically, for Resident #10 comprehensive care plans were not developed and/or implemented to address hearing impairment to allow for clear communication between facility staff and Resident #10, bladder and bowel incontinence, and to address bilateral hand joint stiffness related to rheumatoid arthritis. The findings are: Resident #10 was admitted with diagnoses including Rheumatoid Arthritis, Hypertension and Hyperlipidemia. The 5/30/24 Quarterly Minimum Data Set (a resident assessment and screening tool) documented Resident #10 had severe cognitive impairment, had highly impaired hearing, did not use a hearing aide, and usually understood but missed some part/intent of message, was occasionally incontinent bladder and bowel incontinence, was not on a toileting program, had no functional limitation in range of motion to the upper and lower extremities and received one day of physical therapy during the last 7 days. During observation on 06/25/24 at 11:11 AM: Resident #10 was in bed stating talk louder. I can't hear you. Resident #10 was unable to respond appropriately to questions being asked and stated come closer. Resident #10 was requesting to be toileted and had noticeable joint stiffness of the bilateral hands. There was no documented evidence in the electronic medical record that person-centered care plans with measurable objectives, time frames and appropriate interventions were developed to address hearing impairment, toileting and/or incontinence, and position/mobility/or range of motion prior to 6/26/24. During interview on 06/27/24 at 11:42 AM. Resident #10's son stated Resident #10 had hearing aids for many years in the past. Hearing aids on admission were not functioning due to the age of devices and needed to be replaced. Family did not wish to pursue offsite audiology visit. Son sent a pair of hearing devices about 2 years ago, but they did not work out. Son stated the staff made efforts to communicate effectively with the resident. Resident #10's son stated the resident had severe rheumatoid arthritis of the hands for many years. The resident was right -handed and tended to focus on the right side. Resident# 10's son stated they had to locate staff during visits to assist Resident #10 with toileting needs. During an interview on 7/1/24 at 11:28 AM the Director of Nursing stated they were responsible for ensuring care plans were developed and that interventions were effective. The Director of Nursing stated they were not always able to keep up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.11(c)(1) 50766

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45478 Based on observations, interviews, and record reviews conducted during the Recertification Survey, it was determined that for 1 of 3 residents (Resident #12) reviewed for accidents, the facility did not ensure that a resident's care plan was revised with new interventions following a fall. Specifically Resident #12 had 7 falls from 9/16/23 to 5/3/24 and care plans were not revised to reflect the recommendations made on accident reports or rehab recommendations. The findings are: The Accident Incident Policy last revised 11/2017 documented it is the policy of the facility to ensure that the environment, the people and systems are such that promotion of resident safety and security of accidents/incidents is vigilantly sustained. To this end the Accident/Incident Report serves as the basis for formally reporting and recording residents' accidents/incidents, and for statistical gathering, tracking and analyzing pertinent data to highlight trends, patterns and factors which may warrant an investigation and or risk management factors. As applicable per NYS Department of Health reporting guidelines, the Director of Nursing or designee with report to Department of Health via HCS. The Admission Minimum Data Set (MDS; a comprehensive resident assessment tool) dated 4/17/23, documented Resident #12's cognition was intact. The resident was always incontinent of bladder and frequently incontinent of bowel. Resident #12 required extensive assist of 1 person for toileting, bed mobility, transfer, walking in room and locomotion on and off the unit. Comprehensive Person-Centered Care Plan created 4/10/23 documented Resident #12 was at risk for falls: Interventions dated 7/10/23 documented the following: Ensure that call bell is within reach at all times and is answered in a timely manner; Encourage to call for assistance; Regularly orient to environment; Provide family/resident education on falls prevention. Accident Incident Report dated 9/16/23 documented resident had a fall and recommendation to monitor resident every 2 hours. Accident Incident Report dated 9/21/23 documented resident had a fall and recommendation to monitor resident every hour. The Rehab recommendation dated 9/29/23 documented to post at station until care card created. The recommendation documented resident is extensive assist of 2 for toileting. Handwritten note at bottom of recommendation documented (Do not leave patient unattended in the toilet. Keep patient supervised during waking hours.) The Self Care Deficit Care Plan dated 4/2023 was blank with no instruction on Activities of Daily Living care to reflect the need of extensive assistance of 2 people for toileting Resident #12. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new care plan was created 10/10/23 titled at risk for falls related to: Resident had actual fall 11/11/23, Related to having COVID and poor safety awareness, Actual fall 11/4/23 due to self-transfer, and fall 12/27/23 due to poor safety awareness. The following were the interventions: footwear will fit properly; Keep areas free of obstructions to reduce the risk of falls or injury; place call bell within reach, when in recliner or wheelchair do 15-minute rounds for safety checks; provide reminders to use ambulation and transfer assist devices. Resident re-educated on safety and continuous call bell use; remind resident to call for assistance before moving from bed to chair and from chair to bed; respond promptly to calls for assist to the toilet. Toilet between 6 AM and 7AM; use alarm to monitor attempts to rise. Has an alarm on bathroom door, resident turns off. All interventions on this care plan were dated 10/10/23. A new intervention dated 10/20/23 documented the following: Bed in lowest position; Proper footwear/nonskid footwear with rubber soles; Evaluate for orthostatic hypotension; Rehab screen to assess need for therapy/positioning--assistive devices as indicated; Use diversional activities and encourage participation in activities. Accident Incident Report dated 11/4/23 documented resident had a fall and recommendation for floor mat and 15-minute monitoring. No documented evidence care plans were revised to include floor mats. On 7/1/24 at 2:34 PM Director of Nursing stated they were responsible for the care plans. Director of Nursing stated they may not have updated the care plan but the staff were made aware of any interventions that were made from any recommendations made. [10 NYCRR 415.11(c)(2)(iii)]

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39308 Based on record review observation and interview conducted during the recertification survey it was determined for 2 of 3 residents reviewed for quality of care (Resident #10 and #2), the facility did not ensure residents received treatment and care in accordance with professional standards of quality. Specifically, 1. Resident #10 had a fall on 4/14/24 which resulted in a nondisplaced transverse fracture of the distal malleolus and the facility did not ensure that a CAM boot (orthopedic device that limits foot movement and protects the area during recovery) and/or physical therapy were provided in a timely manner as per orthopedic recommendation and 2. Resident #22 with diagnoses including end stage renal disease had pruiritis(itchy skin) which resulted in visible excoriation/s (breaks in the skin) and the physician was not notified resulting in a delay of treatment. Findings include: 1. The 3/7/24 Quarterly Minimum Data Set Assessment documented Resident #10 had severe cognitive impairment, no functional limitation of the upper and lower extremities, walked up to 150 feet with partial/moderate assist using a walker, received partial/moderate assist of 1 staff for transfers, and did not receive therapy. The 4/14/24 Accident and Incident Report documented Resident #10 had a fall at 3:00 PM in their room and was able to move all extremities without complaint of pain. Extremities equal in length, slight bruising to the right ankle. No swelling noted. 9:30 PM note documented right ankle swelling with hematoma. Medical Doctor made aware and ordered an X-ray. The 4/15/24 Therapy Screening Tool documented recommend orthopedic consult, resident currently on isolation precautions. The therapy screen was updated on 4/17/24 and documented X-ray revealed unhealed nondisplaced transverse fracture of the right distal malleolus *Note received X-ray results from nursing on Resident had orthopedic appointment scheduled for 5/10/24. Therapy will wait for orthopedic recommendations. The 5/10/24 orthopedic consult note documented weight bear as tolerated, CAM boot when ambulating, physical and occupational therapies, check skin daily to access for skin injury, and follow up in 4 weeks. The therapy screen was updated on 5/14/24 and documented this writer gave information to the Director of Nursing and secretary to place the CAM boot order. Therapy will wait for the CAM boot to be delivered to assess the resident. The 5/20/24 Therapy Screening Tool Note documented skilled physical therapy is not indicated at this time until CAM boot recommended by orthopedics for ambulation arrives. Continue to follow toileting schedule established by nursing. Perform frequent room checks. Increase supervision in caring circle. Resident is non-ambulatory at this time. Use wheelchair for transfers. The 5/29/24 physician order documented physical therapy evaluation and treatment as indicated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/29/24 physical therapy evaluation and treatment assessment summary documented resident presents possible fracture on the right ankle and required skilled physical therapy interventions for gait training with CAM boot to preserve the residents ability to ambulate safely to decrease the risk of complications related to decreased mobility such as falls and decreased participation in functional daily activity. The 5/30/24 Quarterly Minimum Data Set documented Resident #10 had severe cognitive impairment. received partial assist with toileting and transfer, walked 10 feet with supervision or touching assistance, had 2 falls with no injury, 1 fall with injury, 0 falls with major injury since admission or most recent assessment and received one day of physical therapy in the last 7 days. The 6/7/24 orthopedic follow up documented assessment plan CAM boot weight bear as tolerated, physical and occupational therapies, ween off CAM boot, skin checks daily, follow up in 6-8 weeks. The 6/7/24 physician order documented right ankle CAM boot must be worn while out of bed. wean off the CAM boot. Check skin integrity every shift for any impairment. There was no documented evidence in the electronic medical record for the use of the CAM boot prior to 6/7/24. The 6/20/24 physician note documented unable to ambulate status post right ankle nondisplaced fracture. Confused. Yelling out at times. Seen by orthopedist. status post right ankle nondisplaced fracture, wheelchair bound, follow up with orthopedist. During an interview on 7/1/24 at 11:45 AM Licensed Practical Nurse #1 stated they did not recall Resident #10 wearing a CAM boot in the past. Licensed Practical Nurse #1 stated they had not signed off in the treatment administration record for the application and/or removal of a CAM boot. During an interview on 7/1/24 at 3:17 PM Certified Nurse Assistant #2 stated Resident # 10 did not wear a CAM boot at any time during the last 6-8 weeks. During an interview on 7/1/24 at 3:29 PM the Director of Nursing stated Resident #10 fell and the soonest orthopedist appointment they could get was 5/10/24. The Director of Nursing stated that a CAM boot was not available at the facility for the residents use. The nursing staff had never ordered orthopedic devices and they thought therapy would order the device. The Director of Nursing stated the facility did not have a policy/ procedure to address ordering devices. Therapy told nursing which CAM boot to order and the Director of Nursing reached out to supply staff at one of the other facilities. At the time of interview email correspondence was reviewed and it was determined that the request for a CAM boot was sent by the facility on 5/14/24 and had an estimated delivery date of 5/17/24. The Director of Nursing stated they were not sure when the CAM boot was actually received. The Director of Nursing stated they had given the CAM boot to therapy and told them to let nursing know what directives should be put in place. When asked if the physician order for the CAM boot was put in place on 6/7/24 the Director of Nursing stated that could be how long it took for the CAM boot to arrive. The Director of Nursing stated they had not updated the physician and/or the administrator regarding the delay in obtaining the orthopedist recommended CAM boot and/or physical therapy assessment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/1/24 at 4:45 PM the Physical Therapy Director stated the CAM boot should be worn for weight bearing due to lower extremity injury. When asked who was responsible for ordering the CAM boot the Physical Therapy Director stated at this facility the ordering is very tricky because everything ordered by therapy required a cash on delivery/ check cut and sent to the supplier before delivery. The Physical Therapy Director stated they did not have a policy regarding device orders at this facility. The Physical Therapy Director stated they would expect nursing to put in a consult order, communicate with therapy and it would be rehabilitation responsibility to order the needed device. Therapy would have to educate staff regarding the use of the CAM boot. Therapy was also responsible for putting in the order for the use of the CAM boot. The Physical Therapy Director stated they remembered that Resident #10 was not evaluated until 5/31/24 and it was documented that the CAM boot was in place. The Physical Therapy Director stated they could not provide more feed back. but stated intervention/s should have been put in place in a much better time frame. This scenario was not ideal. During interview on 7/1/24 at 4:30 PM Central Supply staff stated they received an email request on 5/14/24 requesting a CAM boot for Resident #10. The boot was ordered on that date and had a delivery date of 5/17/24. Central Supply staff stated they had confirmation that the CAM boot was delivered to the facility on [DATE]. Central Supply staff stated they did not normally get these types of orders and they were not sure why this order came their way. 48847 2. Resident #22 was admitted with diagnoses including acute pyelonephritis, diabetes, and end date renal disease. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #22 had moderately impaired cognition, was independent with eating, and required total assistance with bed mobility, toileting, and transfers. The Skin Care Plan dated 12/20/23 documented Resident #22 was at risk for skin breakdown related to history of acute kidney disease, and nephrostomy tube in right kidney with interventions including monitoring for any skin breakdown and report to the medical doctor or nurse practitioner. On 06/25/24 at 10:22 AM, Resident #22 was observed in their room sitting on their bed and was aggressively scratching their back. There were multiple scratches observed on both legs. Resident #22 stated that their back was itching. On 06/25/24 at 10:53 AM, Resident #22 was observed in their room scratching all over their body. There were multiple scratches observed on both upper and lower arms and legs. Resident #22 stated that their back itched very bad and that they had not received any cream for the itching. On 06/26/24 at 09:40 AM, Resident #22 was observed in their room scratching their back aggressively. Resident #22 stated that their back itched and did not know why and that their body had been itching for a long time. There were multiple scratches observed on back and both upper and lower arms. On 06/27/24 at 11:25 AM, Resident #22 stated that staff was aware that they were itching and had not done anything about it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 11:27 AM, Certified Nurse Aide #6 stated that Resident #22 had been complaining about itchiness and scratching. Certified Nurse Aide #6 stated that approximately three days prior they observed that Resident #22 had scratches on their body and that they notified Licensed Practical Nurse #2. Certified Nurse Aide #6 stated that the nurse did not assess the resident, they just said that Resident #22 was scratching due to kidney disease and to apply lotion and petroleum jelly to their body. During an interview on 06/27/24 at 11:34 AM, Registered Nurse #1 stated that they were not aware that Resident #22 had been scratching and they had not done a body audit to see any breaks in Resident #22 skin. During an interview on 06/27/24 at 12:54 PM, Registered Nurse #2 stated that they worked at the facility three days prior and that the Certified Nurse Aide alerted them about Resident #22 scratching their skin and that Resident #22 always had dry skin, and that the Certified Nurse Aides should put lotion on dry skin as a part of the daily routine. During an interview on 06/27/24 at 03:52 PM, the Medical Director stated that they were recently at the facility and was not notified that Resident #22 was itching and scratching their skin causing excoriations and did not receive any correspondences from nursing staff prior to or after their recent visit to the facility. The Medical Director stated that Resident #22 has end stage renal disease which causes dry and itchy skin, and that regular lotion would not relieve the symptoms and they would prescribe a moisturizing cream for staff to apply to Resident #22's skin. Furthermore, the Medical Director stated that Resident #22 should have had moisturizing cream prescribed to be given as needed. 10 NYCRR 415.11(c)(2)(ii)

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F 0689 Level of Harm - 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** 39308 Based on record review, observation and interview conducted during a recertification survey the facility failed to ensure that adequate supervision and effective use of the facility's monitoring program to prevent falls and injuries were provided for 2 of 3 residents reviewed for accidents (Resident #10 and #12). Specifically, (1) Resident #10 was care planned to be on 30-minute monitoring after a 4/12/24 fall. Resident #10 had a second fall on 4/14/24 which resulted in a nondisplaced transverse fracture of the distal malleolus (a break in the small prominent bone on either side of the ankle) and the facility did not implement care plan changes to address recurrent falls and (2) Resident #12 had 6 falls between 9/16/23 and 5/3/24 and the facility did not implement new interventions, including toileting schedules and monitoring, as recommended on the Accident/Incident reports. This resulted in multiple hospitalization s and the resident sustained fractured ribs from the falls on 9/16/23 and 5/3/24. This resulted in actual harm that is not immediate jeopardy. Findings include: The January 2023 Fall Risk Assessment and Prevention policy and procedure documented it was the policy that all residents be free of falls, and free of injuries associated with falls. Implement common sense interventions to aide in the prevention of falls. There was no standard approach to planning preventative care. Each resident must have an individual plan considering risk factors, functional status, cognitive status and how the plan of care will affect the quality of life. 1) Resident #10 was admitted with diagnoses including but not limited to rheumatoid arthritis, anemia (low levels of healthy red blood cells), and hypertension (high blood pressure). The 10/10/23 care plan titled At Risk for Falls, documented actual fall/s 11/14/23, 11/29/23, 3/21/24, 4/12/24, 4/14/24 and 5/18/24. Interventions included but were not limited to place call bell within reach. The care plan documented the following undated intervention reminders to use the call bell, 30-minute monitoring, and toileting schedule. The 3/7/24 Quarterly Minimum Data Set Assessment (a resident assessment tool) documented Resident #10 had severe cognitive impairment, no rejection of care, received partial/moderate assistance for chair to bed transfers, toilet transfers and ambulation up to 50 feet, was frequently incontinent of bladder and continent of bowel, was not on a toileting program, had 1 fall with no injury since admission or prior assessment and did not receive therapy. The 3/27/24 Fall Risk Assessment score is 10 (a score of 4 or more was considered at risk). The 4/12/24 Accident and Incident Report documented Resident #10 had an unwitnessed fall and was observed lying on the floor of their room on their left side at 6:00 PM. Contributing factor was dementia. The resident had COVID and was weak and more confused than normal. The resident was alert/confused. The resident was unable to state what happened. The resident was able to ambulate without obvious injury. The care plan was updated to reflect 30-minute monitoring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 4/14/24 Accident and Incident Report documented Resident #10 had an unwitnessed fall and was observed at 3:00 PM on the floor at the foot of their bed near the bathroom door. The resident was last seen at 2:00 PM. The resident had COVID and was weak, had cognitive deficit and poor safety awareness. The resident was able to get around, when not sick, using a walker. The resident still felt they could use a walker. Slight bruising to the right ankle. There was no documented evidence in the electronic medical record to indicate 30-minute monitoring was put in place or that Resident #10 was on a toileting schedule as per care plan after the 4/12/24 fall and before the 4/14/24 fall. The 4/14/24 nursing progress note documented they were called to the room at 3:00 PM and the resident was sitting on the ground beside the bed. The bed was in the low position. The call bell was not ringing. The resident was unable to say what happened. The resident was able to move all extremities without complaint of pain. The extremities were equal in length, a slight bruise was noted to the right ankle, and continue to monitor. The 4/14/24 nursing progress note documented the resident's right ankle was noted with a hematoma and swelling. The resident was able to move the ankle with some pain noted. The resident was non weight bearing to extremities. Unable to keep the extremity elevated and the resident continued to move the leg off of the pillow. The medical doctor was made aware, and an order was received for an x ray of the right ankle. X Ray called and will be done tomorrow. The 4/17/24 X-Ray Report documented an unhealed non-displaced transverse fracture of the distal malleolus. No overlying soft tissue swelling. Correlate clinically for recent trauma. No significant arthritic changes. Mild soft tissue swelling over the lateral malleolus. Osteoporosis. During observation on 6/25/24 at 11:10 AM Resident # 10 was observed attempting to get out of bed without assistance and stated they had to go the bathroom. Resident #10 had one sock on the right foot, and no sock on the left foot. Both sneakers were on the floor next to the chair. The call bell was wrapped around the right upper siderail and dangling down to the floor. The call bell was not within the resident reach. At 11:13 AM facility staff was made aware Resident #10 was attempting to get up out of bed without assistance. During observation on 6/26/24 at 9:03 AM Resident #10 was observed in bed. Resident #10 had one sock on the right foot and no sock on the left foot. The call bell was on the chair next to the bed, and not within reach. During observation on 6/27/24 at 1:07 PM Resident #10 was in the main lobby and requested to go back to their room. Certified Nurse Assistant #2 returned the resident to their room placed them in bed with a blanket covering and left the room. The call bell was wrapped around the right upper siderail and dangling to the floor. The call bell was not within the resident's reach. Certified Nurse Assistant #2 did not ask Resident #10 if they needed to be toileted prior to placing the resident back to bed. During observation on 6/27/24 at 4:54 PM Resident #10 was observed sitting up at the edge of the bed on the right side attempting to get up unassisted as they stated help me, help me, please take me to the bathroom. The call bell was wrapped around the right upper siderail and not within the resident's reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/27/24 at 4:42 PM when asked where they documented safety monitoring and the toileting schedule for Resident #10, Certified Nurse Assistant # 1 stated Resident #10 had never been on a toileting and/or safety monitoring schedule. Certified Nurse Assistant #1 stated that most days Resident #10 preferred to stay in their bed and they checked on them maybe 3 times during their shift. Certified Nurse Assistant #1 stated they often found Resident #10's call bell on the siderail and dangling to the floor on either side of the bed and not within the resident's reach when starting their shift. During an interview on 6/27/24 at 5:00 PM Registered Nurse #1 stated Resident #10 would yell out when they had to go to the bathroom, but they were not sure if the resident was incontinent or on a toilet schedule. Registered Nurse #1 stated they did not know if Resident #10 had falls in the past, but due to the resident's current state they would assume Resident #10 was high risk for falls. Registered Nurse #1 stated if a resident were high risk for falls, they should have the call bell within reach at all times and be frequently supervised. Registered Nurse #1 stated the care plan would direct toileting and fall risk needs, but they did not have access to the care plans. When asked how certified nurse assistants received information regarding resident care needs, Registered Nurse #1 stated they only provided the certified nurse assistants with report if something was going on with the resident otherwise the certified nurse assistants reported to each other. During an interview 6/28/24 at 11:17 AM Certified Nurse Assistant #2 stated they were not certain if Resident #10 had falls in the past, or if they had ever been on 30-minute monitoring. Certified Nurse Assistant #2 stated they would not know how to document resident monitoring. Certified Nurse Assistant #2 stated Resident # 10 loved to sleep in bed, so they put the resident back to bed after breakfast. Certified Nurse Assistant #2 stated Resident #10 was not currently on a documented toileting or monitoring schedule and they checked on the resident every 2 hours when they were in bed. During an interview on 6/28/24 at 11:50 AM the Medical Director stated everybody in the nursing home was a high risk for falls. The physician stated when a resident had a fall, they were educated on the use of the call bell. The physician stated they were part of the QAPI (Quality Assurance and Performance Improvement) and that they reviewed falls, performance and improvement plans. During an interview on 7/1/24 at 11:22 AM the Director of Nursing stated they believed the fall care plan had been updated after the 4/12/24 fall to reflect 30-minute monitoring. The Director of Nursing stated they had also discussed the resident being placed on a toilet schedule during the fall meetings and that a toilet schedule should have been put in place but was not. The Director of Nursing stated they were responsible for ensuring monitoring of residents for fall prevention and documentation for such monitoring was done. The Director of Nursing stated they were not able to locate documentation to support that monitoring for Resident #10 occurred or remained ongoing as per care plan intervention. The Director of Nursing stated they were responsible for ensuring that care plan interventions were developed and effective. The Director of Nursing stated they were responsible for supervising staff during the week and supervisors were responsible during the weekends. The Director of Nursing stated whenever they noticed Resident #10's call bell was not within reach they put it within the residents reach. The Director of Nursing stated they had not educated staff regarding the call bell not being kept within the resident's reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/1/24 at 12:45 PM the Administrator stated they had been the Administrator onsite since October 2023 and had not identified any concerns with how the facility operated. The Administrator stated they approved Accident and Incident reports submitted by the Director of Nursing. The Administrator stated that during fall meetings they discussed what transpired and what was put in place for each resident to prevent future reoccurrence. The Administrator stated they did not recall being made aware of any resident being seriously injured related to falls. 2) Resident #12 was admitted to the facility on [DATE] with diagnoses and conditions including Congestive Heart Failure (heart pumps inadequately causing fluid overload), Diabetes (uncontrolled blood sugar), and Depression (sadness). The Admission Minimum Data Set (MDS; a comprehensive resident assessment tool) dated 4/17/23, documented Resident #12's cognition was intact. The resident was always incontinent of bladder and frequently incontinent of bowel. Resident #12 required extensive assist of 1 person for toileting, bed mobility, transfer, walking in room and locomotion on and off the unit. Comprehensive Person-Centered Care Plan dated 4/10/23 documented Resident #12 was at risk for falls. Interventions dated 7/10/23 included ensuring the call bell was within reach at all times and was answered in a timely manner; encourage to call for assistance; regularly orient to environment; and provide family/resident education on falls prevention. An Accident/Incident Report dated 9/16/23 documented on 9/16/23 at 11:20 PM the nurse was called to the resident's bathroom, observed resident on floor on their back, resident complained of low back pain and able to move legs. Resident #12's color was pale and had seizure like activity for short period, head fell back, and eyes were wide open. The recommendation was for medical workup and was sent to the hospital. The Accident/Incident report also recommended to monitor resident every 2 hours. The nursing progress note dated 9/17/23 at 6:40 AM, documented the resident was admitted to the hospital for syncope(losing consciousness)/fall. The Hospital Visit Summary dated 9/20/23, documented the resident's discharge diagnoses included pacemaker, fall, and closed fracture multiple ribs of right side. The nursing progress note dated 9/20/23, documented the resident was readmitted to the facility. There was no documented evidence to include 2-hour monitoring as recommended on the Accident/Incident report dated 9/16/23. An Accident/Incident Report dated 9/21/23 documented at 2:00 PM the resident was assisted to bathroom by the Certified Nurse Assistant. The Certified Nurse Assistant left the resident alone and resident fell off the toilet to floor. The resident was sent to Emergency Department for evaluation. The recommendation was for 1 hour monitoring when in room and not to be left alone on toilet. Hospital records dated 9/21/23 to 9/28/23 documented the resident passed out after having a bowel movement while getting up from the toilet. The diagnosis was defecation syncope. The resident also needed a change for his pacemaker and was transferred to another hospital for the procedure. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note dated 9/28/23 for 3-11 PM, documented the resident returned to the facility with a pacemaker replacement due to syncope. Review of the resident record revealed no documented evidence the recommendation for 1 hour monitoring when in room and not to be left alone on toilet was put in place. The new admission rehabilitation evaluation and recommendation dated 9/29/23, documented the resident was non-ambulatory with nursing staff, may only ambulate during therapy as appropriate. Do not leave resident unattended in the toilet. Keep resident in supervised area during working hours. There was no documented evidence of the care plan being revised with the recommendations from the Rehabilitation Department. A nursing note dated 10/5/23 at 3:11 PM, documented Resident #12 was observed lying on the floor in the bathroom, reported hitting the side of their forehead, and complained of nausea and right hip pain, pupils reacting to light able to move upper extremities. The family member was made aware, and the resident was transferred to the hospital. There was no documented evidence of an investigation being completed or an Accident/Incident report for 10/5/23. During an interview on 7/01/24 at 3:28 PM, the Director of Nursing stated an Accident/Incident report was not done for 10/5/23 as they were not told about the incident. A Physical Therapy note dated 10/11/23 at 12:40 PM, documented the resident required extensive assist of 1 for transfers. The resident was non ambulatory with nursing staff and could ambulate only with rehabilitation staff at this time. The resident required supervision at all times especially in the toilet due to history of multiple falls. A Physical Therapy note dated 10/17/23 at 9:38 AM, documented nursing staff could ambulate the resident to and from the bathroom using rollator with 1 assist for safety. Do not leave the resident unsupervised while at the bathroom due to history of multiple falls. A new care plan intervention dated 10/20/23 documented the following: Bed in lowest position; Proper footwear/nonskid footwear with rubber soles; Evaluate for orthostatic hypotension; Rehabilitation screen to assess need for therapy/positioning--assistive devices as indicated; Use diversional activities and encourage participation in activities. The Accident/Incident Report dated 11/4/23 documented they were called to the resident's room and the resident was observed on their left side on the floor, resident stated they attempted to get out of bed without calling for assistance. Educated to ask for assistance able to move all extremities. The Care plan was updated in resident chart for a floor mat left side. The Accident /Incident Report recommended floor mat and 15-minute monitoring. There was no documented monitoring and no documented instructions for the Certified Nurse Assistant to do 15-minute monitoring. Review of the resident's care plan documented a fall on 11/11/23; however, no other documentation including an Accident/Incident report was found for this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Accident/Incident Report dated 12/27/23 documented at 7:44 AM, the resident fell was observed lying on the floor on their back, knees bent, feet facing bathroom door. The resident attempted to get up and did not ring bell. The documented recommendation was to set up the resident on the night get up schedule (the overnight shift gets the resident up for morning care), and toileting schedule 6:00 -7:00 AM. There was no documented evidence on Certified Nurse Assistant instructions of a toileting schedule for Resident #12. The Accident/Incident Report dated 5/3/24 documented at 3:04 AM the resident fell and had a skin tear. Resident #12 got up to go to the bathroom and did not use the call bell. It further documented the resident had poor safety awareness, cognitive deficits and was self-directed. Resident #12 was sent to the hospital due to seizure like activity. The documented recommendation was for resident to be put on a toileting schedule. Nursing note dated 5/10/24 documented the resident was readmitted to facility from the hospital on 5/9/24 and had sustained rib fractures from their fall on 5/3/24. Review of Resident #12's medical record revealed no documented evidence the resident was ever put on 2-hour, 1 hour, or 15-minute monitoring as planned on the Accident/Incident reports dated 9/16/23 to 5/3/24. There was no documented evidence on the Certified Nurse Assistant instructions for the recommended toileting schedule for Resident #12. On 6/26/24 at 4:00 PM, as the surveyor was approaching Residents #12's room, the Certified Nurse Assistant was observed walking toward the room and stated they were toileting the resident. The resident had been left in the bathroom unattended. There was a sign on the bathroom door that read Do not leave wheelchair in bathroom if left unattended. Please do not leave resident unsupervised in bathroom. On 6/27/24 at 10:29 AM, Resident #12 was observed lying in bed. The bathroom door was open and an alarm on door trim upper left side was observed. Resident #12 was interviewed and stated the alarm was used to notify nursing they were using the bathroom. They stated it was put in place when they were having a lot of falls. Stated they did not use it much now. They stated the device needed to be turned on and bathroom door kept closed, and then when the door to bathroom was opened, the alarm would sound. On 6/27/2024 at 11:24 AM, a family member of Resident #12 stated Resident #12 had a history of falls prior to admission to the facility and after Resident #12 was admitted they began falling in the facility. Resident #12 and family were offered an alarm on resident's bathroom door as an intervention to prevent further falls around September or October of 2023. The resident's family agreed to have alarm placed on the door. On 6/28/24 at 9:17 AM, Resident #12 stated the last fall they had was bad and they were still recovering. They stated they were still waiting to see if the swelling of the hematoma goes down and they might need surgery. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/28/24 at 10:25 AM, Certified Nurse Assistant #4 stated Resident #12 was alert and oriented and supposed to ring bell when they needed assistance. On 5/3/24, during the overnight shift, the resident used the urinal then started to be sick and was unable to really tell you what happened. Certified Nurse Assistant #4 stated usually when they worked the overnight shift, they did not get residents up, they just changed them. Certified Nurse Assistant #4 stated there were no new interventions in place for toileting Resident #12. On 6/28/24 at 10:26 AM, Certified Nurse Assistant #8 stated they were assigned to Resident #12 and had been working at the facility since February 2024. Certified Nurse Assistant #8 stated Resident #12 could not be in their wheelchair in their room alone because they would use the bathroom unassisted. Certified Nurse Assistant #8 stated because the resident was mobile, for safety precaution, Resident #12 should be out in the common areas where they could be supervised. Certified Nurse Assistant #8 stated there was not a toileting schedule for Resident #12 and they were unaware of any planned monitoring schedule. Certified Nurse Assistant #8 stated during report after the resident's last fall, the nurse told them verbally that the resident could not be left alone in their room, but it was not on the care instructions. On 06/28/24 at 10:28 AM, the Resident #12 was observed in his room alone, sitting in his recliner chair with a wheelchair nearby. On 6/28/24 at 10:43 AM, Licensed Practical Nurse #3 stated they were notified at change of shift of residents who were at risk for falls and those residents needed to be brought to the common area. Licensed Practical Nurse #3 stated Resident #12 was supposed to be in the common area and that basically every resident went to the common area for lunch and stayed there after lunch. Licensed Practical Nurse #3 stated they did not know how the facility identified residents at risk for falling and was unaware of any documented monitoring for residents at risk for falls. They stated they just kept an eye on those at risk. Licensed Practical Nurse #3 stated Resident #12 used their call bell and sometimes it took a long time to answer call bells especially if they had no help to do cares, treatments, and when there was a shortage of Certified Nurse Assistants. On 6/28/24 at 10:38 AM, Certified Nurse Assistant #5 stated they were usually assigned to Resident #12 on the overnight shift. Certified Nurse Assistant #5 stated they were off the night of the most recent fall but when they returned to work nothing was changed, there were no new interventions. Certified Nurse Assistant #5 stated the alarm on the bathroom door was there the whole time they have worked with the resident. Certified Nurse Assistant #5 stated there was no toileting schedule put in place. Certified Nurse Assistant #5 stated they did frequently monitor all residents but was not told to do 15-minute monitoring for Resident #12 and had not documented any type of monitoring. On 06/28/24 at 11:15 AM, the resident was observed on the toilet with the wheelchair in front of him and Licensed Practical Nurse #3 was standing outside of the room in the corridor. Licensed Practical Nurse #3 stated that resident rang the bell to use the bathroom and they were outside of the room to give the resident privacy because they were having a bowel movement. Licensed Practical Nurse #3 stated there was no documented 15-minute checks. Licensed Practical Nurse #3 stated they were not aware of the motion sensor on resident's bathroom door. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/28/24 at 11:50 AM, Medical Director and primary physician for residents at the facility stated everybody in the nursing home was at high risk for falls. Medical Director stated Resident #12 had a fall and was hospitalized with a pneumothorax (collapsed lung), hematoma and rib fractures. The Medical Director stated the interventions in place prior to hospitalization were to do a rehabilitation referral, educate resident and in-service staff. On 6/28/24 12:24 PM, Physical Therapist #1 stated the resident was moderate to high risk for falls and had multiple falls at the facility. Physical Therapist #1 stated their recommendation was to keep the resident supervised and not leave the resident unattended while in the bathroom. Physical Therapist #1 stated when they wrote their notes with recommendations for changes, it was the responsibility of the charge nurse or Director of Nursing to read their notes. On 7/01/24 at 10:35 AM, Resident #12 was observed in the recliner chair alone. Resident #12 stated they liked to go the common area but most of the time the staff did not bring them there. On 7/01/24 at 2:34 PM, the Director of Nursing stated the staff were aware of the toileting schedule and they were not sure why it was not implemented. They stated the care plan might not have been updated, but the staff were made aware. The alarm on the bathroom door was supposed to be turned on all the time and the resident would get annoyed and would turn it off with their reacher (device used to assist in grabbing items that the resident cannot reach). The Director of Nursing stated the staff should still be using the alarm. The Director of Nursing stated when toileting the resident the Certified Nurse Assistant must stay in the room or right outside of the bathroom to give them privacy but should not be down the hall. The Director of Nursing stated Resident #12 sustained a hematoma and fractured ribs with the fall in May 2024, and did not remember the time the resident fractured ribs in September 2023. The Director of Nursing stated when Resident #12 was in the recliner the staff checked on them but there was not documentation of that monitoring. The Director of Nursing stated the staff should be checking on Resident #12 often but would not specify how often. 415.12(h)(2) 45478

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Arden Inc	46 Harriman Drive Goshen, NY 10924

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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** 48847 Based on observation, record review and interviews conducted during the recertification survey from 6/25/2024 to 7/2/2024, the facility did not ensure that all drugs and biologicals were stored in accordance with the manufacturer's specifications and professional standard of practice. Specifically, the medication storage room was observed with expired medical equipment that was used to administer medications. Findings include: The facility's policy titled Medication Storage in the Facility dated 8/22/2014 documented that outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if applicable. On 07/01/24 at 10:40 AM, the medication storage room was observed with three expired 20 gauge needles with an expiration date of 2/29/23, five-43 inch 9 millimeter Medtronic quick sets with an expiration date of 3/1/23, and one intravenous dressing change kit with [NAME] prep swabs with an expiration date on 3/31/24. During an interview on 07/01/24 at 10:43 AM, the Director of Nursing stated that the expired equipment was not supposed to be in the medication storage room and that they would discard them. The Director of Nursing stated that they were in possession of the key to the storage room and that they were responsible for going through the things that were kept in there, especially for expired medications. The Director of Nursing stated that nothing should be expired in the med room whether it was being used or not, and stated they would get rid of the expired items and go through the rest of the storage room to see if anything else was expired and needed to be discarded. 10NYCRR 483.45 (g)(h)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45478 Based on observation, interview, and record review during the recertification survey, the facility did not provide food and drink that was at a safe and appetizing temperature for 3 of 5 food items (shrimp salad, cucumber salad, baked chicken/fish was the alternate, and apricots) being served from a steam table during the dining experience. Specifically, the baked chicken, shrimp salad and apricots were registered temperatures ranges in the danger zone (temperatures above 41 degrees Fahrenheit (F) and below 135 degrees (F), and that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. The findings are: During an interview with Resident #141 on 6/25/24 at 11:08 AM, they stated the food was constantly cold at dinner time. Resident #141 stated they could not recall the exact date but about 2 weeks ago they plated food, and it took 30 minutes to deliver trays. During an observation on 6/27/24 at 12:11 PM, while servers were prepping food for tray distribution from steam table, temperatures were taken on the shrimp salad, cucumber salad, baked chicken, fish and apricots. The Food Service Director put the thermometer in the shrimp salad and the temperature was taken and read 50 degrees Fahrenheit, the baked chicken was 127.5 degrees Fahrenheit, and the apricots were 46 degrees Fahrenheit. When interviewed on 7/02/24 at 10:02 AM, the Food Service Director stated the hot/cold station steam table just started being used about 6 months ago. Food Service Director stated the steam table station did keep the temperatures at an acceptable level. Food Service Director stated the hot food should be over 140 degrees (F) and the cold food should be under 40 degrees (F). 10NYCRR 415.14(d)(1)(2)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 40686 Based on observation, interview, and record review conducted during the post-survey revisit from 9/3/2024 to 9/5/2024, the facility did not ensure the medical director was responsible for implementation of resident care policies and the coordination of medical care in the facility. Specifically, the new Medical Director hired on 8/1/2024 was unaware of their responsibilities as a medical director and had no previous nursing home experience, was not a part of the quality assurance committee, and did not assess residents until 12 days after hire date. The findings are: The facility Medical Director Agreement dated 7/29/2024 documented the Medical Director shall be responsible for assuring each resident's responsible physician attends to the resident's medical needs, participates in care planning, follows the schedule of visits in accordance with 10 NYCRR 415.15(b), and complies with the facility policies, rules, regulations, and medical staff by-laws. Please refer to F689. On 9/5/2024 at 3:54 PM, the Medical Director was interviewed and stated they were the only physician on staff at the facility. The facility did not employ a Nurse Practitioner or Physician Assistant. The Medical Director stated they did not confer with the former Medical Director of the facility before starting their position on 8/1/2024, did not come to the facility to see residents until 8/12/2024, did not document their notes in the medical record upon assessing or visiting with residents, did not know the regulations related to Medical Director responsibilities in the State Operations Manual, and was not part of the facility Quality Assurance Committee upon being hired. The Medical Director did not take part in any staff meetings, did not take part in any Quality Assurance Committee meetings, and was not introduced to staff since being hired. The Medical Director stated they have never worked in a skilled nursing facility prior to being hired by the facility and was not familiar with working with a geriatric population. On 9/4/2024 at 2:05 PM and 3:31 PM and 9/5/2024 at 6:56 PM, the Administrator was interviewed and stated they were hired by the facility on 8/19/2024 and forgot the name of the new Medical Director that was hired by the facility on 8/1/2024. The Administrator stated they just met the new Medical Director on 9/4/2024 for the first time. The Administrator stated the facility did not meet with residents or family members to introduce the new Medical Director. The Administrator was unable to provide information related to Medical Director visits to the facility, hours at the facility, or billing for resident visits since their hire date. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/2024 at 7:01 PM, the Assistant Administrator was interviewed and stated the former Administrator was responsible for interviewing the new Medical Director prior to their start with the facility on 8/1/2024. The Assistant Administrator provided the Medical Director with the contact information for the former Medical Director and encouraged them to communicate to ensure the new Medical Director was acclimated to the facility and continuity of resident care between physicians. The Assistant Administrator stated they did not confirm whether the former Medical Director and the new Medical Director communicated with each other. The Assistant Administrator stated they met with the new Medical Director prior to their hire date but was unsure who was responsible for approving the hiring of the new Medical Director to work at the facility. 10 NYCRR 415.26(e)(1)(i-iv)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 48847 Based on observation, record review, and interviews conducted during the recertification survey from 6/25/24-7/02/2024 the facility did not ensure an infection prevention and control program was designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #19 and #22) of 4 residents reviewed. Specifically, Resident #19 had a urostomy tube and Resident #22 had a nephrostomy tube, and enhanced barrier precautions were not implemented. Findings include: The facility's policy titled Transmission Based Precautions/Enhanced Barrier Precautions dated 12/15/2022 documented that enhanced barrier precautions are meant to prevent the spread of multi drug resistant organisms. They are used with all residents with indwelling medical devices. The principles of Enhanced Barrier precautions are that staff will use a gown and gloves during high contact resident care activities only and is intended to be used for resident's entire length of stay; or while they have indwelling devices/wounds. 1) Resident #22 was admitted with diagnoses including acute pyelonephritis, diabetes, and end date renal disease. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #22 had moderately impaired cognition, was independent with eating, and required total assistance with bed mobility, toileting, and transfers. Physician orders dated 5/17/24 documented Resident #22 was on enhanced precautions due to Nephrostomy tube. Review of the Care Plans revealed that there was no Enhanced Barrier Precautions care plan. On 06/25/24 at 10:22 AM, Resident #22 was observed in their room sitting on bed while Staff #6(certified nurse's aide) was observed in room providing care to resident and assisting them out of bed. There was a dressing with a white tube observed on the resident's right lower back. Resident #22 stated that they had a nephrostomy tube. Staff #6 was observed not wearing any personal protective equipment while giving care. There was no signage on the door indicating Resident #22 was on Enhanced Barrier Precaution, and there was not a personal protective equipment cart in sight. On 06/25/24 at 10:53 AM, Resident #22 was observed in their room and there were no enhanced barrier precautions signage observed on the resident's door or a personal protective equipment cart in sight. On 06/26/24 at 09:40 AM, Resident #22 was observed in their room and there were no Enhanced Barrier Precautions signage observed on the door and no personal protective equipment carts in sight. On 06/27/24 at 11:38 AM, there were no Enhanced Barrier Precautions signage or personal protective carts outside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/27/24 at 11:27 AM, Staff #6(certified nurse's aide) stated that Resident #22 had a nephrostomy tube and that they required extensive assistance with activities of a daily living. During an interview on 06/27/24 at 11:34 AM, Staff #1(registered nurse) stated that they were not aware that Resident #22 was on Enhanced Barrier Precautions and had not seen staff gown up when providing cares to the resident. During an interview on 06/27/24 at 11:46 AM, Staff #3(certified nurse's aide) stated they were not aware that Resident #22 was on Enhanced Barrier Precautions and had not seen any precautions signs or carts outside of the resident's room since the pandemic. Staff #3(certified nurse's aide) stated that they did not wear a gown when they provided care to the resident. During an interview on 06/27/24 at 11:47 AM, Staff #6(certified nurse's aide) stated that they never had to gown up while providing cares to Resident #22 and did not remember being educated on enhanced barrier precaution, they only remembered a paper going around to sign. During an interview on 06/27/24 at 12:02 PM, the Infection Control Preventionist stated that if a resident had a nephrostomy or urostomy tube, they should have had a sign and a personal protective equipment cart outside of their door. During an interview on 06/27/24 at 12:06 PM, the Director of Nursing stated that Resident #22 should have been on Enhanced Barrier Precautions and there should have been a sign on the door with instructions and a personal protective equipment cart outside of the room. 2) Resident #19 was admitted with diagnoses including acute kidney failure, metabolic encephalopathy, and ostomy in place to right lower middle abdomen. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #19 had intact cognition, was independent with eating, and required moderate assistance with bed mobility, toileting, and transfers, and had an ostomy. Review of the physicians' orders and the care plans revealed that there were no Enhanced Barrier Precautions in place. On 6/27/24 at 12:43 PM, Resident #19 was observed in their room and stated that they had a urostomy tube. Resident #19 stated that although they did not require assistance with routine activities of a daily living, they did require assistance with showering and staff did not wear gowns when giving them shower. There was no Enhanced Barrier Precautions signage observed on the door or any personal protective equipment observed near their room. 10 NYCRR 415.19(a)(2)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 40686 Based on observation, interview, and record review conducted during the recertification survey from 6/25/2024 to 7/2/2024, the facility did not ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public was provided. This was evident during environmental observation of the kitchen, staff lounge, housekeeping closet, and ancillary services room. Specifically, a sheet of ice was observed covering the kitchen freezer floor, the staff lounge and housekeeping closet had stained ceiling tiles, and the ancillary services room had several items stored on the floor. The findings are: The facility policy titled Safety Committee Policy dated 4/21/2024 documented the Safety Committee was responsible for identifying issues pertaining to the environment and managing safety, and hazardous materials and wastes. On 06/25/24 at 10:01 AM, 6/26/2024 from 9:30 AM to 5:00 PM, and 6/27/2024 from 9:30 AM to 5:00 PM, the facility was observed with the following: - staff lounge locker room and bathroom with stained ceiling tiles, - the ancillary services room had boxed supplies containing gauze sponges, Hoyer lifter pads, Sani-cloths, and razors stored directly on the floor, - the kitchen freezer had a sheet of ice approximately a 1/2 inch thick covering the floor. On 6/27/2024 at 4:00 PM, the Director of Environmental Services was interviewed and stated the facility planned to replace the stained ceiling tiles throughout the facility once they stopped a leak on Unit 1 and repaired the roof. After observing the ancillary services room, the Director of Environmental Services stated they would ensure all items were removed from the floor and stored appropriately. The kitchen freezer floor was cleaned daily by housekeeping staff at the end of each shift. On 07/02/2024 at 10:02 AM, the Food Service Director was interviewed and stated the kitchen freezer accumulated ice on the floor due to condensation. As the freezer door opens, the hot air from the kitchen causes condensation in the freezer that drips and then freezes on the freezer floor. The freezer did not have a drain. A new dietary worker was recently hired and was in the process of being trained on their responsibility to mop and clean the freezer floor regularly to prevent ice from forming. The dietary staff were responsible for reporting concerns related to icy freezer floors to the Food Service Director but have not reported any concerns. The Food Service Director stated they conducted daily rounds of the kitchen and provided oversight of the dietary staff to ensure they performed their job duties. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/02/2024 at 10:45 AM, the Administrator was interviewed and stated ongoing negotiations for another nonprofit owner to acquire the facility has caused renovation and repair delays. The Unit 1 ceiling leak occurred sporadically after rainstorms. The facility hired a roof repair company. The Maintenance Department had a logbook where staff documented their requests for repairs. The Environmental Services Director checked the logbook daily. The Administrator stated they also conducted environmental rounds of the facility when on site and communicated any observation concerns to the Director of Environmental Services. 10 NYCRR 415.29