STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335824	A. Building B. Wing	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Putnam Ridge	46 MT Ebo Road North Brewster, NY 10509

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48847 Based on observation, record review and interview conducted during a recertification survey, the facility did not ensure for 1 of 5 residents (Resident #62), reviewed for activities of daily living, that care was provided in a manner to maintain dignity. Specifically, the urinary (Foley) catheter bag for Resident #62 was not concealed to prevent direct observation by other residents and their families. Findings include: A facility policy titled, Urinary Catheter Care, last revised 9/21, documented that privacy must be provided when a resident has the presence of an indwelling urethral catheter. Resident # 62 was admitted with diagnoses including but not limited to cerebral infarction, chronic kidney disease, and atrial fibrillation. The Significant Change Minimum Data Set (MDS - an assessment tool) dated 7/30/2023, documented that Resident #105 had moderately impaired cognition and was totally dependent of 2 or more staff for toilet use, and required the extensive assistance of 1 staff member for assistance with personal hygiene. A physician order dated 10/15/23 documented Resident #62's catheter should be secured to their outer thigh daily for both leg bag and bedside bag every shift. During observations on 10/17/23 at 10:15 AM, 10/17/23 at 1:00 PM, and 10/18/23 at 8:11 AM, Resident #62 was observed from the public hallway in their bed with a foley catheter bag hanging from the bedframe unconcealed with urine visible to residents, staff, and visitors passing through the hallway. During an interview on 10/23/23 at 11:45 AM, CNA #14 stated they were unsure why Resident #62's foley bag was uncovered and visible from the hallway, and stated that Resident #62's foley catheter bag should be covered. During an interview on 10/23/23 at 12:05 PM, registered nurse (RN) #4 stated they were going to call the supply room and have some dignity bags sent up. (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	During an interview on 10/23/23 at 12:29 PM, the Director of Nursing stated they have spoken to staff previously regarding foley catheter bags and it continues to be a problem. The Director of Nursing stated staff should be providing privacy for resident's with foley catheters. 10NYCRR 415.5 48045

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record reviews and interviews during the recertification survey from 10/17/23-10/25/23, the facility did not ensure that the call bell system was accessible for 7 (Residents #115, #60, #105, #109, #132, #72 and #12) of 12 residents reviewed for Environment. Specifically, multiple observations revealed that call bells designated for Residents #115, #60, #105, #109, #132, #72 and #12, were not within the resident's reach. The findings are: 1.) Resident #115 was admitted to the facility with diagnoses including anxiety disorder, senile degeneration of the brain, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented Resident #115 had severely impaired cognition and required supervision with bed mobility and transfers, and extensive assist of one staff with toileting. The fall care plan dated 4/11/22, documented for the call bell to be within reach. On 10/17/23 at 09:48 AM, Resident #115 was observed in bed awake, the call bell was hanging on the wall and was not within reach. 2.) Resident #60 was admitted with diagnoses including unspecified dementia, history of transient ischemic and peripheral vascular disease. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #60 had severely impaired cognition. The urinary, bowel incontinence, and urinary tract infection prevention care plan dated 6/14/22, documented to have call bell within reach. On 10/17/23 at 10:05 AM, Resident #60 was observed in bed awake, the call bell was not within the reach. 3) Resident #105 was admitted to the facility with diagnoses including vascular dementia, major depressive disorder and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented Resident #105 had moderately impaired cognition and required extensive assist of two staff with bed mobility, toileting, and transfers. The falls care plan dated 12/6/22, documented to have the call bell within reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/23 at 10:06 AM, Resident #105 was observed in their room sitting in the wheelchair. The call bell was on the wall and not with in the residents reach; Resident #105 stated that when assistance was needed, they screamed attendant, attendant, to notify the staff. Resident #105 demonstrated use of the call bell and stated that staff never put the call bell within their reach. 4) Resident #109 was admitted to the facility with diagnoses including unspecified dementia, epilepsy, and asthma. The Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented Resident #109 had moderately impaired cognition and required extensive assist of one staff with bed mobility and extensive assist of two staff with toileting and transfers. The fall care plan dated 3/17/22, documented to have the call bell within reach. On 10/17/23 at 10:09 AM, Resident #109 was observed in bed awake, the call bell was hanging on the wall and not within reach. 5.) Resident #132 was admitted with diagnoses including unspecified dementia, acute kidney failure, and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #132 had severely impaired cognition and required supervision for bed mobility and limited assist of one staff with toileting and transfers. The falls care plan dated 5/16/23, documented to have the call bell within reach. On 10/17/23 at 10:12 AM, Resident #132 was observed in bed, the call bell was on the wall and was not within reach. 6) Resident #72 was admitted with diagnoses including diabetes and hyperlipidemia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented Resident #72 had severely impaired cognition and required extensive assist of two staff with bed mobility and total assist of two staff with transfers and toilet use. The urinary, bowel incontinence, and urinary tract infection prevention care plan dated 7/10/22, documented to have the call bell in easy reach. On 10/17/23 at 10:18 AM, Resident #72 was observed laying in bed asleep, the call bell was hanging on the wall and not within reach. 7) Resident #12 was admitted with diagnoses including Alzheimer's disease, generalized anxiety disorder and insomnia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], documented Resident #12 had severely impaired cognition. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The urinary, bowel incontinence, and urinary tract infection prevention care plan with a revision date of 9/22/23, documented to have call bell in easy reach. On 10/17/23 at 10:37 AM, Resident #12 was observed awake in bed, the call bell was on the wall behind the bed, and not within reach. During an interview on 10/17/23 at 10:41 AM, certified nurse aide (CNA) #2 stated that all residents should have their call bells with in reach. CNA #2 stated it was in the CNA care guide. During an interview on 10/18/23 at 10:53 AM, CNA #5 stated that all call bells were to be placed within reach of the residents and not hanging on the walls. CNA #5 stated it was documented in the CNA care guide. During an interview on 10/25/23 at 01:37 PM, licensed practical nurse (LPN) #5 stated that all residents must have call bells within reach and that the instructions were in the CNA care guide. During an interview on 10/25/23 at 01:44 PM, the Director of Nursing (DON) stated that the residents must have call bells within reach and that all staff should follow the care plan for care of the residents. 10NYCRR 415.3

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48849 Based on record review and interview conducted during the recertification and abbreviated surveys (# NY00317914) from 10/17 to 10/25/23, the facility did not ensure all injuries of unknown origin were thoroughly investigated and reported to the New York State Department of Health (NYSDOH) for 1 of 2 residents reviewed for abuse. Specifically, Resident #449 reported an unwittnessed fall and broken arm that was not thoroughly investigated to rule out abuse. Findings include: Resident # 449 was admitted on [DATE] with diagnoses including stroke, non-traumatic brain dysfunction, Parkinson's, and dementia. The Fall Risk assessment dated [DATE] documented the resident had intermittent confusion, required use of an assistive device for gait and balance, had a history of falls and was at high risk for falls. The Skilled Nursing Progress note dated 9/20/22 at 10:05 PM, documented Resident #449 was alert with periods of confusion and required contact guard and limited assistance with transfers and toileting. The facility Accident/Incident (A/I) Report dated 9/22/2022,documented: - Resident #449 reported to staff at 7:45 AM that they had a broken arm. - The day nurse was informed by the night nurse that the resident was complaing of a broken arm and was found to have a skin tear below the left knee and would not allow the arm to be assessed due to pain. - The resident had a bruise/hematoma to the right arm, and upper arm and elbow pain. - The resident reported they got themself up after falling at an unknown time. The resident's statement, dated 9/22/22, and written by registered nurse (RN) #3 documented I fell during the night out of my bed and broke my arm. I got up really carefully. The nursing progress note dated 9/22/22 at 9:28 AM, documented the resident had an unwittnessed fall at an unknown time, and was observed in bed. The resident was guarding the right upper arm and refused staff to assess it. Pain scale was 8/10 (severe pain) to the right upper arm and there was a skin tear with minimal bleeding 2 centimetershematoma below the left knee. The resident was sent to the hospital for evaluation. The resident did not give a statement regarding how the left knee skin tear occurred and was unable to explain why he got out of bed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Summary of Investigation Report, dated 9/22/22 and signed by RN #3 and Director of Nursing (DON) on 9/22/22, documented the resident stated he fell out of bed during the night and got back into bed unassisted and broke his arm. The resident was assessed and sent to the Emergency Department for evaluation of the right arm and hematoma with skin tear to below the left knee. The investigation did not check off if there was reasonable or no reasonable cause to believe that alleged resident abuse, mistreatment or neglect had occured to the resident. The assigned certified nurse aide (CNA) #13 statement dated 9/27/22 (5 days after the injury of unknown origin) documented CNA #13 last saw the resident at 6:46 AM in bed when they assisted the resident to the bathroom and actively participated in the transfer. The transfer was a one person assist. Resident was applying pressure to wrist during his assists to the restroom throughout the evening and never mentioned feeling any discomfort or that a fall had occured. The licensed practical nurse (LPN) #8 statement dated 9/27/22 (5 days after the injury), documented the resident was seen by LPN # 8 and the CNA multiple times during the night and the resident was able to put weight on both hands and arms. Late in the morning the resident said their arm was broken, resident was not found on floor at any time during the night. Range of motion of the arm was performed with good result and resident showed no signs of pain. When asked multiple times if they had any pain, the resident did not answer. LPN #8 passed on in report that the resident said their arm was broken so that on coming nurse would be aware. When interviewed on10/24/23 at 03:53 PM, the DON stated the injuries of unknown origin were not further investigated based on the resident's statement and staff statements. The DON stated not checking the determination on the A/I report as to if it could be considered abuse or neglect was an oversight and they determined it was not abuse. Therefore it was not further investigated or reported to the NYSDOH. In summary, the facility did not ensure the injuries of unknown origin, including a broken arm and a skin tear with hematoma, were thorougly investigated. There was no investigation as to how the resident fell from the bed or any environmental factor that could have contributed, or interviews with other staff or residents. 10NYCRR 415.4

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48847 Based on observation, interview and record review conducted during the recertification survey from 10/17/23 to 10/25/23, the facility did not ensure that each resident who was unable to carry out activities of daily living (ADL) received the necessary care and services to maintain good personal hygiene for one (Residents #64) of five residents reviewed for ADL's. Specifically, Resident #64 was observed on multiple occasions with urine-soaked pants and on one occassion was observed not out of bed as planned. Findings include: Resident #64 was admitted with diagnoses including but not limited to vascular dementia, hypothyroidism, muscle weakness, and orthostatic hypotension. The Comprehensive Minimum Data Set (MDS - an assessment tool) dated 7/26/23, documented Resident #64 had severely impaired cognition, and required extensive assist of two with toileting and transfers. The 11/25/2020 urinary/bowel incontinence/UTI prevention care plan documented the resident was incontinent of bladder and was to be toileted. Interventions included incontinent cares every two hours and as needed, and to provide incontinence brief, care/toileting and to notify the doctor of any changes. The 10/17/2023 physician order documented out of bed to merry walker and remove for meals, hygiene, and toileting. The ADL function care plan, updated on 10/17/23, documented the resident required assistance with ADLs. The interventions included an early get up on the 11 PM-7 AM shift, and toileting/incontinent cares as scheduled and as needed. Resident #64 was observed on 10/18/23: - at 9:28 AM, in the hallway sitting in the Merri walker with urine-soaked pants. - at 10:42 AM, rolling up and down the hallway in the Merri walker with urine-soaked pants. - at 10:55 AM, in the hallway sleeping with urine-soaked pants while sitting in the Merri walker. When interviewed on 10/18/23 at 10:53 AM, certified nursing aide (CNA) #5 stated Resident #64 was gotten up by the 11 PM-7 AM shift and was already up out of bed when they started their shift at 7 AM. CNA #5 stated Resident #64 had not been changed since the start of their shift and would be provided care after lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 10/18/23 at 10:56 AM, licensed practical nurse (LPN) #5 stated Resident #64 was to be taken out of bed during the 11 PM-7 AM shift. LPN #5 stated Resident #64 had not been toileted since the start of the 7 AM-3 PM shift and Resident #64 should be toileted every 2 hours and as needed. When interviewed on 10/23/23 at 11:19 AM, CNA #6 stated Resident #64 usually got up at 4 AM and did not get toileted until after lunch. When observed on 10/25/2023 at 10:08 AM, Resident #64 was awake and in bed. When interviewed on 10/25/2023 at 10:12 AM, CNA # 3 stated that Resident #64 was in bed at 7AM when the shift started and they did not know why the resident was in bed. CNA #3 stated Resident #64 was supposed to gotten up by the 11 PM to 7 AM shift according to their plan. When interviewed on 10/25/23 at 10:14 AM, LPN #3 stated Resident #64 was supposed to be an early get up, and did not know why they were not out of bed. When interviewed on 10/25/23 at 10:57 AM, LPN #5 stated that Resident #64 was supposed to be gotten out of bed by the night shift and was unaware the resident was still in bed. When interviewed on 10/25/23 at 11:03 AM, the DON stated that night shift was aware that Resident #64 was care planned to get out of bed on the 11PM-7 AM shift. 10 NYCRR 415.12

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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** 48847 Based on observation, record review, and interview during the recertification and abbreviated (NY00312435, NY00323395) surveys conducted 10/17/232023 - 10/25/2023, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 3 of 8 residents (Resident #23, #299, and #105) reviewed for quality of care. Specifically, 1) Resident #23, had a physician order for Clonazepam (anxiety medication) and received an incorrect dose. 2) Resident #299 was sent to a medical appointment without an aide and the consultant physician refused to see the resident without an aide. 3) Resident #105 was administered crushed medications without a physician's order. Findings include: 1.) Resident #23 had diagnoses including Alzheimer's disease, hyperlipidemia, and major depressive disorder. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severe cognitive impairment, required extensive assistance of one for bed mobility and transfers, extensive assist of two with toileting, total assist of one with eating, was an antipsychotic and antidepressant on a routine basis. The facility's policy titled Medication Administration dated 12/16 and revised on 01/2022, documented that all medications needed to be administered in a safe and systematic way. When an order is discontinued, it will be removed from EMAR/ETAR as per protocol The physicians order dated 5/10/23, documented Clonazepam 0.25 milligram (mg) disintegrating tablet to be placed on top tongue where it will be dissolved, then swallow by oral route three times a day for anxiety disorder. Medical progress note dated 5/12/23 written by NP #1, documented the nurse manager reported the resident received Clonazepam 0.5mg and not the prescribed dose of Clonazepam 0.25mg twice today, and the higher dose was what Resident #23 was previously taking, until yesterday when it was reduced to 0.25mg due to lethargy. A Medication discipline warning notice dated 5/16/23, documented LPN #2 performed a medication error on 5/11/23. When interviewed on 10/25/23 at 12:32 PM, LPN #5 stated that on 5/11/23, Resident #23 received Clonazepam 0.50 mg and not the prescribed dose of Clonazepam 0.25mg, and a medication discipline warning notice for a medication error was given to LPN #2. When interviewed on 10/25/23 at 12:38 PM, LPN #2 stated that on 5/11/23, Resident #23 was given Clonazepam 0.50 mg and not the prescribed dose of Clonazepam 0.25mg, and that a medication discipline warning notice for a medication error was received. LPN #2 stated that nurses must verify all physician orders before a medication is given to residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 10/25/23 at 01:40 PM, the DON stated that a medication discipline warning notice for a medication error was given to LPN #2 for administering Clonazepam 0.50 mg to Resident #23 and not the prescribed dose of Clonazepam 0.25mg. 2) Resident #299 was admitted to the facility for short term rehabilitation on 8/9/23 with diagnoses including fracture of T9-T10 vertebra, diabetes, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment 9/5/23 documented the resident's cognition was intact and the resident had a fall with fracture in the last 2-6 months. The physician order dated 8/9/23 documented resident may go out on pass with family or outside appointment. The Out of House Appointment and Transportation Worksheet dated 8/9/23, documented Resident #299 was scheduled for an orthopedic consult appointment on 9/7/23 at 9:30 AM, and transport was arranged with ambulette for pick up at 8:30 AM. A handwritten note at bottom of the worksheet noted not seen, must have nurse aide and images, never notified. The check boxes on the form for family notification and the need for a CNA escort were left blank. When interviewed on 10/24/23 10:16 AM, the Unit Secretary stated when the appointment for 9/7/23 was set up, they were unaware a nurse aide needed to go to the appointment. They stated they were notified the resident could not be seen without an aide after the appointment. The US stated they knew the Out of House Appointment and Transportation Worksheet had a place to enter if a CAN escort was needed and place to document family notification, but stated they never filled the worksheet out completely. The US stated the physician's office did not provide instructions to send an aide and they did ask if one was needed. They also stated there was a shortage of staff to go with residents on appointments. When interviewed on 10/24/23 at 3:41 PM, the Director of Nursing (DON) stated the Unit Secretary was responsible for calling the physician/consultant's office to schedule outside appointments. The Unit Secretary needed to coordinate with the facility scheduling person if the resident needed a nurse aide to go on the appointment. The DON stated they were not aware Resident #299 was not seen at the 9/7/23 ortho consult appointment due to a lack of staff in attendance. The DON stated the Unit Secretary was responsible for getting the information for the appointment whether they needed an escort or a stretcher or anything specific. The DON reviewed the Out of House Appointment and Transportation Worksheets and stated the form was incomplete and the Unit Secretary was responsible for completing the form in full. 3) Resident #105 had diagnoses including vascular dementia, depressive disorder and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS - an assessment tool) dated 8/19/2023, documented that Resident #105 had moderately impaired cognition. The physician order dated 10/22/2023 documented the resident was to be given fluids with medication pass every shift, and was on a regular diet and consistency, and thin liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The polypharmacy care plan dated 12/6/2022, documented an intervention for the administration of medications as prescribed by the physician or nurse practitioner. On 10/17/23 at 10:06 AM, licensed practical nurse (LPN) # 4 was observed giving Resident #105 crushed medications. LPN #4 stated that Resident #105 was given crushed medications because they had a cough. Resident 105's October 2023 Medication Administration Record (MAR) revealed 10 AM medications included Entresto 24mg-26 mg tablet, enteric coated aspirin 81 mg delayed release tablet, and acetaminophen 325 mg tablet. There were no instructions to crush medications. During an interview on 10/23/23 at 10:16 AM, LPN #4 stated Resident #105 was supposed to receive their medications whole and with liquids. LPN #4 stated that there were no orders in place for the resident to receive crushed medications and they were not supposed to crushed medications without a physician order. During an interview on 10/23/23 at 10:52 AM, licensed practical nurse unit manager (LPNUM) #5 stated that in order to give crushed medications a doctor order was required. LPN # 5 stated they were not aware that Resident #105 had a cough or that the nurse was crushing Resident # 105's medications. During an interview on 10/23/23 at 11:35 AM, medical doctor (MD) #1 stated that it was not acceptable to crush medications without a physician order. MD #1 also stated they did not know that Resident #105 had a cough and if residents were having difficulties with medication administration, the nurse should notify the doctor immediately. 10NYCRR 415.12

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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 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** 45478 Based on record review and interview conducted during a recertification survey, the facility did not ensure that adequate supervision was provided to prevent accidents for 1 of 9 residents (Resident #302) reviewed for accidents. Specifically, Resident #302 who was assessed at high risk for falls on admission and was observed attempting to stand up from their wheelchair without staff assistance or redirection. The findings are: Resident #302 was admitted on [DATE] with diagnoses including lack of coordination, non-displaced fracture of seventh cervical vertebra, and dementia without behavioral disturbance. The fall assessment dated [DATE] documented the resident was at high risk for falls with score of 17. The occupational therapy (OT) evaluation dated 10/14/23 documented the resident assessment identified 3-5 deficits in areas of physical, cognitive, psychosocial skills resulting in activity limitation or participation restrictions. The resident presented with impairments in balance, mobility and strength resulting in limitations or participation restrictions in the areas of general tasks and demands, mobility and self-care. The fall care plan dated 10/16/23 documented the resident was at risk for falls and interventions included keeping in a supervised area when out of bed. On 10/17/23 at 12:00 PM, Resident #302 was observed trying to stand up from their wheelchair in the TV room. Resident # 302 was seated at the edge of their wheelchair seat. Two staff member were standing in the TV room and did not redirect the resident to sit back/down in the wheelchair. The surveyor alerted training nurse aide (TNA) #1 that Resident #302 was attempting to stand up and was seated at the edge of their wheel chair seat. TNA #1 went to get assistance while the Unit Assistant stayed with the resident. On 10/18/23 at 10:08 AM, Resident #302 was observed sleeping in wheelchair in TV room, feet positioned between foot pedals not resting on the foot pedals; the resident's body had slid down in the wheelchair. On 10/20/23 at 10:24 AM, Resident #302 was observed sitting in the dining room in a gown in the wheelchair with a pillow behind their back, feet on the floor between the pedals, and leaning forward trying to get out of the wheelchair. No staff were present during this observation. When Interviewed on 10/24/23 at 3:06 PM, the Unit Assistant (UA) stated they watched residents when they were in the Day Room but did not assist the resident with cares. The UA stated if a resident needed assistance they would call the nurse or aide. When asked why they did not get help when resident was attempting to stand up and UA stated they did not understand English well. (continued on next page)

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	335824	A. Building B. Wing	10/25/2023

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When Interviewed on 10/24/23 at 3:22 PM , training nurse aide (TNA) #1 stated if they saw a resident trying to get up from their wheelchair they would assist the resident and encourage them to sit down. TNA #1 stated the Unit Assistant could not assist with cares and was why they did not assist when resident was attempting to stand up. TNA #1 stated the resident was a fall risk and they now had a seatbelt. 10NYCRR415.12(h)(2)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on review of facility records, observation and interview during the recertification and abbreviated surveys (#NY00311199), from [DATE] through [DATE], it was determined the facility did not ensure any individual working in the facility as a nurse aide for more than 4 months was competent to provide nursing and nursing related services, for 7 of 7 staff (Training Nurse Aide (TNA) #1-#7) reviewed for training. Specifically, TNAs were employed by the facility and functioned in the role of a nurse aide for greater than 4 months without receiving nurse aide certification. Findings include: The Centers for Medicare and Medicaid Services (CMS) published a quality, safety and oversight memorandum (QSO-,d+[DATE]-NH-TLTC-LSC), originally dated [DATE], which documented that previous staffing waivers allowing nurse aides to work for greater than 4 months without completing a state-approved nurse aide competency evaluation program or passing an oral or written exam expired on [DATE], which required facilities to ensure that anyone functioning as a nurses aide in the facility completed a State approved nurse aide training program and oral/written examination within 4 months of hire. Review of facility records revealed 7 staff were functioning as full-time nurse aides without certification. This included: -TNA #1 was hired as a training nurse aide on [DATE]. -TNA #2 was hired as a training nurse aide on [DATE]. -TNA #3 was hired as a training nurse aide on [DATE]. -TNA #4 was originally hired by the facility on [DATE] and began functioning as a training nurse aide on [DATE]. -TNA #5 was hired as a training nurse aide on [DATE]. -TNA #6 was hired as a training nurse aide on [DATE]. -TNA #7 was hired as a training nurse aide on [DATE]. During an interview on [DATE] at 12:12 PM, the Director of Human Resources stated TNA's functioned as certified nurse aides (CNA). The Director of Human Resources stated they were aware the waiver was listed and believed the TNAs were permitted to work until [DATE], and they had been giving the TNAs verbal reminders to complete their CNA certification since [DATE]. During an interview on [DATE] at 11:59 AM, the Director of Nursing (DON) stated they expect nurse aides were competent and certified prior to performing care on residents. The DON stated they were aware they had non-certified nurse aides working and stated staffing was a major problem at the facility. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10NYCRR 415.26(c)(2)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on staff interview and review of facility records during the recertification and abbreviated surveys (NY311199) form 10/17 to 10/25/23, it was determined the facility did not ensure each certified nurse aide received twelve hours of in-service education per year, based on their individual performance review for 4 of 8 CNAs (CNA #8, #9, #10 and #11) reviewed for inservices. Specifically, CNA #8 lacked 6 hours of training; CNA #9 lacked 10 hours of training; CNA #10 lacked 8.5 hours of training, and CNA #11 lacked 7 hours of training; and all 4 CNAs lacked an annual performance evaluation. Finding Include: Review of the facility records for in-service education, provided by the Infection Control Nurse/Educator (IP) #1, revealed: - CNA #8 received 6 hours of in-service in 2023, and the last performance evaluation was completed 12/12/20. - CNA #9 received 2 hours of in-service in 2023, and the last performance evaluation was completed 9/7/22. - CNA #10 received 3.5 hours of in-service in 2023, and the last performance evaluation was completed 2/12/20. - CNA #11 received 5 hours of in-service in 2023, and the last performance evaluation was completed 7/2/21. When interviewed on 10/20/23 at 4:07 PM and on 10/25/23 at 2:41 PM, IP #1 stated that all in-services were provided and there were no more documented inservices for CNAs #8, 9, 10, and 11. IP #1 stated in-services were not completed due to the pandemic as no one was meeting at that time. When interviewed on 10/25/23 at 4:03 PM, CNA #8 stated they had been employed at facility for [AGE] years and that the last evaluation they had was about 2-3 years ago and they were supposed to be evaluated every year. When interviewed on 10/25/23 at 4:05 PM, the Director of Nursing (DON) stated they inherited what was not completed. The DON stated the Nurse Managers did the evaluations for the CNAs and they were behind. DON stated were working on catching up the in-service/education and evaluations. 10NYCRR 415.26(c)(2)(iii)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 48045 Based on observations, record review, and interviews conducted during the recertification survey from 10/17/23 to 10/25/23, the facility did not ensure a medication error rate of no more than 5%, during a medication administration observation, when 3 of 25 opportunities (12%) resulted in error and impacted 2 of 6 residents (Resident #132 and #136). Specifically, 1) Resident # 132 was administered Metoprolol Extended Release Tablet crushed instead of whole, and 2) Resident #136 was administered medication through a feeding tube without flushing between 2 medications. The findings are: The facility's policy titled Medication Administration dated 12/16 documented that nurses should double check and ensure all medications were administered to patient/resident as per MD order. 1. Resident #132 was admitted to the facility with diagnoses including but not limited to diabetes, chronic kidney disease, and heart failure. The current physician order as of 10/23/23, documented to administer metoprolol succinate ER 50 milligram tablet extended-release 24 hr, by mouth once daily for ventricular tachycardia and heart failure. The current physician order as of 10/23/23 documented Resident #132 received a regular diet, with liquids of thin consistency allowed. The Food and Drug Administration Drug Data Guide (NDA 19-962/S-032), last revised 3/2006, documented Metoprolol succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed. During a medication administration observation on 10/23/23 at 9:44 AM, Licensed Practical Nurse (LPN) #4 was observed crushing Resident #132's metoprolol extended release 50 mg tablet prior to mixing the medication with pudding and administering to Resident #132. During an interview on 10/24/23 at 9:41 AM, LPN #4 stated they crush all the resident's pills regardless of whether or not they can swallow or the physician's order, because all of the residents on the unit have dementia and none of them swallow whole pills. 2. Resident #136 was admitted to the facility with diagnoses including cerebral palsy, dysphagia, and heart failure. The current physician order as of 10/23/23 documented Resident #136 receives 30 milliliters (mL) Prostat three times daily via their feeding tube, and baclofen 20 mg three times daily through their feeding tube. During a medication administration observation on 10/23/23 at 2:48 pm, LPN #7 was observed not flushing Resident #136's feeding tube with water between the administration of the Prostat and the Baclofen. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/23 at 2:50 PM, LPN #7 was unable to provide reasoning why they did not flush Resident #136's feeding tube between giving separate medications. During an interview on 10/24/23 at 9:58 AM, the Director of Nursing (DON) stated medications should be given in accordance with professional standards and physician orders. The DON stated extended-release medications should not be crushed and feeding tubes should be flushed between the administration of different medications. 10NYCRR 415.12(m)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48045 Based on observation, interview, and record review during the recertification survey conducted 10/17/23 through 10/25/23, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 4 medication carts (Cedar and Apple). Specifically, medications were not stored in a clean environment on medication carts located on the Cedar and Apple units and undated/expired drugs and biologicals were discovered on medication carts of the Cedar and Apple unit. Findings include: A facility policy titled, Medication Storage, last revised 4/2014 documented medications should be stored in an orderly, organized manner in a clean area and that expired/discontinued/contaminated medications will be removed from the medication storage areas and disposed. During a medication storage observation on 10/24/23 at 5:30 PM, with Registered Nurse (RN) #2, the following was observed on the Cedar Unit medication cart: -1 undated, opened tobramycin eye drops -1 undated, opened bottle of olopatadine eye drops -1 undated, opened bottle of bacitracin ophthalmic ointment -1 undated, opened bottle of Latanoprost eye drops -1 daily probiotic supplement with an expiration date of 10/6/2023 -1 undated, opened bottle of Geri-Lanta -2 undated, opened bottles of Chlorohexidine Gluconate oral rise solution -1 opened bottle of ferrous gluconate with a date of 6/6/22 written on the bottle -1 opened, undated bottle of carbamazepine -Excessive amounts of debris including medication wrappers, mouth swabs, used medication packaging, multiple unpackaged and unlabeled pills were noted to be covering the bottom and sides of the medication cart drawers, in addition to multiple unidentifiable sticky residue and debris. During an interview on 10/24/23 at 5:40 PM, RN #2 stated nurses should be cleaning the medication carts weekly and the facility's pharmacy consultant should have caught the expired/undated medications during their monthly visits. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication storage observation on 10/24/23 at 6:38 PM with LPN #3, the following was observed on the Apple Unit medication cart: -An unidentifiable pill in an unlabeled pill-crusher sleeve was observed on the bottom of the 2nd drawer -1 bottle of NUTRI-Stat dated 7/1/23 -1 bottle of NUTRI-Stat dated 8/10/23 with a grimy, sticky substance covering the bottle -3 opened, undated bottles of Chlorahexidine Gluconate oral rinse solution -1 bottle of polyvynil alcohol lubricating eyedrops with a date 9/8 written on the outer bag -1 bottle of artificial tears with a date 8/3 written on the outer bag -Multiple unidentifiable, sticky residue and debris were observed on the bottom of the medication cart During an interview on 10/24/23 at 6:50 PM, LPN #3 stated nurses were supposed to be cleaning the medication carts and removing expired/undated medications. During an interview on 10/24/23 at 7:23 PM, the Director of Nursing (DON) stated staff should be dating bottles when opened and should be cleaning the medication carts routinely. The DON stated medications should have been discarded 30 days after opening. 10 NYCRR 415.18 (d)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44673 Based on observation and interview conducted during a recertification survey conducted [DATE] through [DATE], the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food safety. Specifically, food items in the walk in refrigerator and the cook's refrigerator were unlabeled and undated. The rack designated for dry pans was wet. The findings are: The policy and procedure titled storage of food in the facility refrigerator dated [DATE] documented,all items must have received dates written. Stored items must be labeled with a name and open date. All items opened and prepared over 72 hours ago must be discarded. The initial tour of the kitchen was conducted on [DATE] from 9:10 AM to 9:50 AM and the following were identified: - A rack of bread with ten loaves of bread in a plastic bag had no receive date. - The walk-in refrigerator had a package of approximately ten slices of cheese that were not labeled or dated; a small pan of applesauce was not labeled; and a small pan of yogurt was dated ,d+[DATE] but not labeled. - The cook's refrigerator had 16.9 ounces of red wine vinegar had no open date; approximately fifty slices of cheese had no label and no date; a 120-milliliter bottle of hot sauce had no open date. - Yellow liquid in small cups had no label and no date; cakes in a baking pan had no label and no date; and cookies in a baking pan had no label. - A rack designated for dry pans contained wet pans. During an interview on [DATE] at 9:15 AM the Assistant Food Service Director (AFSD) stated all food items were supposed to be labeled and dated. The AFSD stated if food items were not labeled and dated the staff would not know when the food items expired and/or what the food items were. The AFSD stated residents could get sick from expired food. During an interview on [DATE] at 10 AM the Food Service Director (FSD) stated all foods should have been dated and labeled and any food item that was older than 3 days should have been discarded as per facility policy. The FSD stated the rack designated for dry pans should only have dry pans. 10NYCRR 415.14(h)