STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335831	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Commons Care Center Inc	60 Merrick Avenue East Meadow, NY 11554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not ensure that each resident had the right to participate in the development and implementation of their person-centered plan of care. This was identified for one (Resident #93) of four residents reviewed for Choices. Specifically, Resident #93, a cognitively intact resident with no known family or designated representative, was not invited to their Comprehensive Care Plan meeting. The finding is: The Care Planning-Interdisciplinary Team Policy and Procedure last reviewed in January 2024 documented that the resident, the resident's family, and/or legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family. The Care Plans, Comprehensive Person-Centered Policy and Procedure last reviewed in January 2024, documented that the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care including, but not limited to, the right to participate in the planning process. Resident #93, who has no known family or designated representative, has diagnoses that include Schizophrenia, Anxiety Disorder, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Minimum Data Set assessment documented Resident #93 was feeling down, depressed, hopeless, had trouble falling or staying asleep, had little energy, felt bad about themselves, and had trouble concentrating on things. The assessment documented Resident #93 received Antipsychotic and Antidepressant medications during the 7-day lookback period. The Social Services Progress Note dated 11/18/2024, written by Social Worker #1, documented the resident had no family contact and that the (Comprehensive Care Plan) meeting would convene with the Interdisciplinary Team. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan Meeting Progress Note dated 11/20/2024, written by Social Worker #1, documented the resident had no family contact and was not able to represent themselves due to periods of confusion. The Interdisciplinary Team members present were Social Worker #1 and a representative from Dietary. It was a quarterly care plan meeting. The resident's plan of care was reviewed and all concerns were addressed. Staff would continue to provide support to the resident, as they remained stable at this time. The resident would remain in the facility for long-term care. During an interview on 12/17/2024 at 12:30 PM, Social Worker #1 stated Resident 93's Brief Interview for Mental Status score was 13 (intact cognition); however, Social Worker #1 did not invite Resident #93 to their care plan meeting that was held on 11/20/2024 because the resident was confused at times. Social Worker #1 stated they should have visited the resident on the day of the care plan meeting to determine the resident's mental status and if the resident was able to participate in their care plan meeting that day. During an interview on 12/17/2024 at 1:50 PM, the Director of Social Services stated Resident #93 should have been invited to their care plan meeting to participate and discuss their wishes. During an interview on 12/17/2024 at 3:20 PM, the Administrator stated it is a resident's right to be invited to their care plan meeting especially if they are cognitively intact. During an interview on 12/18/2024 at 10:00 AM, Resident #93 stated they would like to be invited to participate in their care plan meetings. 10 NYCRR 415.11(c)(2)(i-iii)

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not develop and implement an effective discharge planning process that focused on the resident's discharge goals. This was identified for one (Resident #93) of four residents reviewed for Choices. Specifically, Resident #93, a cognitively intact resident with no known family or designated representative, requested a transfer to another nursing facility; however, the facility did not address the resident's request to meet the resident's discharge goals. The finding is: The Discharge Summary and Plan Policy and Procedure last reviewed in January 2024 documented that when the facility anticipates a resident's discharge to a private residence, or another nursing care facility, a discharge summary, and the post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and their family. Residents will be asked about their interest in returning to the community. If the resident indicates an interest in returning to the community, they will be referred to local agencies and support services that can assist in accommodating the resident's post-discharge preferences. If it is determined that returning to the community is not feasible, it will be documented why this is the case and who made the decision. Resident #93, who has no known family or designated representative, has diagnoses that include Paranoid schizophrenia and Depression. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated that the resident had intact cognitive skills for daily decision-making. Section Q0310 A, the resident's overall goal for discharge established during the assessment process was left blank. The Psychiatry Consultation dated 10/21/2024 documented the resident felt unhappy, lonely, and had no primary support. Recommendations included for Social Services to discuss with the resident their nursing home options in Suffolk County and for the resident to receive Behavior Therapy or counseling. The Psychiatry Consultation dated 12/06/2024 documented the resident reported they would like to move to a facility in Suffolk County. The recommendations included but were not limited to providing social work support to discuss nursing home options in Suffolk County as per the resident's request and for the resident to receive Behavior Therapy or counseling. The Physician's Order dated 12/8/2024 documented for the resident to receive Social work support to discuss nursing home options in Suffolk County as per the resident's request. A review of the resident's Electronic Medical Record on 12/17/2024 at 11:30 AM revealed no documented evidence that Social Services had discussed discharge planning options with the resident to a nursing home in Suffolk County. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 12:30 PM, Social Worker #1, who was the resident's assigned Social Worker, stated discharge planning was not their responsibility. The facility has a Discharge Planner, who was also a Social Worker responsible for discharge planning. Social Worker #1 stated they discussed the possibility of the resident being discharged to another nursing home in Suffolk County with the facility's Discharge Planner and they both agreed the resident was not a candidate due to the resident being confused at times. Social Worker #1 stated that they should have documented their discussion with the Discharge Planner. Social Worker #1 stated that they never went to the resident to discuss discharge planning because the resident was confused at times. During an interview on 12/17/2024 at 1:50 PM, the Director of Social Services stated Social Worker #1 should have met with the resident to discuss the options for transferring to another nursing home in Suffolk County. The Director of Social Services stated Social Worker #1 should have also met with the resident to know why they no longer wanted to live in this facility so that their experience in this facility could be a better one. During an interview on 12/17/2024 at 3:10 PM, the Discharge Planner stated if a resident was requesting to transfer to another facility, the resident's Social Worker should speak with the resident, and then relay the information to the Discharge Planner. The Discharge Planner stated they were not aware of the Physician's Order for Resident #93's discharge request to a Suffolk County nursing home and did not recall discussing the resident's request with Social Worker #1. The Discharge Planner stated they should have met with the resident to discuss why the resident wanted a transfer to another facility and to facilitate the transfer. During an interview on 12/17/2024 at 3:20 PM, the Administrator stated it is a resident's right to be invited to their care plan meetings. The Administrator stated the Physician's Order to explore Suffolk County nursing home options for Resident #93 should have been followed. During an interview on 12/18/2024 at 10:00 AM, Resident #93 stated before coming to this facility they had lived in a group home. The resident stated they wanted to be placed in a group home in Suffolk County because they thought they could be placed in a facility faster in Suffolk County, but they would be okay being placed in [NAME] County as well. 10 NYCRR 415.11(d)(3)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and interviews conducted during the Recertification Survey completed on 12/23/2024, the facility did not ensure that residents received proper assistive devices to maintain hearing abilities. This was identified for one (Resident #59) of two residents reviewed for Communication. Specifically, Resident #59, with highly impaired hearing had a Physician's order to use the hearing aids for both ears. The facility staff did not recharge the hearing aids consequently Resident #59 was not able to use the hearing aids to effectively communicate with staff and peers. The finding is: The facility's Policy titled Hearing Aid; Rechargeable Type dated 1/2024 documented guidelines including: storing the resident's hearing aids in the charger, away from direct sunlight or very warm temperatures when not in use. Check specific manufacturer's instructions for care of the hearing aid and charger. It is recommended to charge the hearing aids every night. Resident #59 was admitted with diagnoses of Type 2 Diabetes Mellitus, Atrial Fibrillation, and Bilateral Hearing Loss. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderately impaired cognition. The Minimum Data Set (MDS) documented the resident had highly impaired hearing and utilized a hearing aid. The Physician's order dated 8/22/2024 documented an order for the hearing aids to the left and right ears. Remove the hearing aids and place on the charger at Sleeping Hours (HS). Place the hearing aids in both ears in the Morning (AM). The Medication and Treatment Administration record for August 2024 to December 2024 did not indicate the resident was provided with their hearing aids every day, and that the hearing aids were recharged as per the Physician's order. The Comprehensive Care Plan (CCP) for Hearing Deficit/Hearing Loss dated 6/19/2024 and revised on 8/22/2024 documented the resident will wear hearing aids as indicated. The interventions included but were not limited to anticipating resident needs and applying the hearing aid (left/right) and care of the hearing aids. During an observation on 12/15/2024 at 10:58 AM, Resident#59 was observed sitting in a wheelchair in the hallway without the hearing aids. Resident#59's family member was observed reporting to Registered Nurse #3 that Resident#59 often did not have their hearing aids on. During an interview on 12/15/2024 at 11:10 AM, Resident#59's family member stated they regularly visited the resident and found them without their hearing aids and always notified the staff that the resident did not have their hearing aids on. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/15/2024 at 11:15 AM, Resident #59 stated the staff do not give them their hearing aids often. Resident #59 stated it was difficult to communicate without their hearing aids. During an interview on 12/15/2024 at 11:30 AM, Registered Nurse Unit Manager #3 stated the overnight nurses were supposed to recharge the hearing aids. Licensed Practical Nurse #8, the overnight nurse, forgot to recharge the resident's hearing aids. Registered Nurse Unit Manager#3 stated they realized that the Physician's order for the hearing aids was never transcribed to the Medication or the Treatment Administration Record to direct the nurses to apply and recharge the hearing aids for Resident #59. During an interview on 12/20/2024 at 8:00 AM, Licensed Practical Nurse #8 stated they were the overnight nurse assigned to Resident #59. Licensed Practical Nurse #8 stated they never recharged Resident #59's hearing aids because the Medication or the Treatment Administration Record did not indicate the Physician's order for the use of the hearing aids. Licensed Practical Nurse #8 stated they did not know Resident #59 had hearing aids until 12/15/2024 when Registered Nurse Unit Manager #3 educated them regarding recharging the resident's hearing aids. During an interview on 12/20/2024 at 11:00 AM, the Director of Nursing Services stated Resident #59 had a Physician's order for bilateral hearing aids and to charge the hearing aids at night. The Director of Nursing Services stated for some unexplained technical issues, the order for the hearing aids did not get transcribed onto either the Treatment Administration Record or Medication Administration Record. The Director of Nursing Services stated the nurses should have charged the hearing aids and placed the hearing aids on the resident as per the Physician's order. 415.12(a)(3)(b)(1-3)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not ensure that the medical care of each resident was supervised by the Physician including monitoring changes in the resident's medical status. This was identified for one (Resident #93) of four residents reviewed for Choices. Specifically, The Psychiatrist's consultation dated 10/21/2024 included recommendations to explore options with the resident for transfer to another facility of the resident's choice and for the resident to receive behavior therapy and counseling. Nurse Practioner #1 reviewed the recommendations provided by the Psychiatrist; however, did not agree, disagree, or implement the recommendations. The finding is: The Consultation Policy and Procedure, last reviewed in January 2024 documented the Physician will approve any orders they agree with on the consultation. The Physician will document the reason if they disagree with the consultant. Resident #93, who has no known family or designated representative, has diagnoses that include Schizophrenia, Anxiety Disorder, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Minimum Data Set assessment documented Resident #93 was feeling down, depressed, hopeless, had trouble falling or staying asleep, had little energy, felt bad about themselves, and had trouble concentrating on things. The assessment documented Resident #93 received Antipsychotic and Antidepressant medications during the 7-day lookback period. The Psychiatry Consultation dated 10/21/2024 documented the resident felt unhappy, lonely, and had no primary support. Recommendations included for Social Services to discuss with the resident their nursing home options in Suffolk County and for the resident to receive behavior therapy or counseling. The Physician's Consult Review Note dated 10/22/2024, written by Nurse Practitioner #1, documented that they reviewed the Psychiatry Consultation dated 10/21/2024. Nurse Practitioner #1 rewrote all the recommendations made by the Psychiatrist in the Psychiatry Consultation dated 10/21/2024; however, did not document whether they agreed or disagreed with the recommendations. The Physician's Order dated 12/8/2024 documented for the resident to receive Social work support to discuss nursing home options in Suffolk County as per the resident's request. During an interview on 12/17/2024 at 5:00 PM, Nurse Practitioner #1 stated they were a remote (does not physically work in the facility) Medical Provider who only reviews the recommendations made by the Psychiatrist. Nurse Practitioner #1 stated they had strict instructions from their Supervisor to not write Physician Orders. Nurse Practitioner #1 stated the in-house Medical Providers are the ones to either agree or disagree with the recommendations made by the Psychiatrist. Nurse Practitioner #1 stated if an in-house Medical Provider agrees with the recommendations made by the Psychiatrist, they would be the one to place the Physician's Orders in the resident's Electronic Medical Record. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 5:25 PM, the resident's Primary Physician (Primary Physician #1) stated a remote Medical Provider can also enter Physician's Orders in the resident's Electronic Medical Record after reviewing a resident's Psychiatry Consultation. Primary Physician #1 stated that a resident cannot receive behavioral (Psychological) counseling without a Physician's Order. Primary Physician #1 stated they were not aware of the Psychiatrist's recommendation for Resident #93 to receive behavioral counseling. During an interview on 12/17/2024 at 6:00 PM, the Medical Director stated that whenever a Medical Provider, either remote or in-house, reviews a Psychiatry Consultation they are to document whether they agree or disagree with the recommendations. The Medical Director stated that the facility has remote Medical Providers to add an extra layer of supervision so that areas of concern related to the resident's medical care are not missed. The Medical Director stated Nurse Practitioner #1 should have referred the resident to Social Services to discuss their nursing home options in Suffolk County and should have also entered a Physician's Order into the resident's Electronic Medical Record for the behavioral (Psychological) counseling services. During an interview on 12/18/2024 at 10:00 AM, the resident stated they had lived in a group home prior to coming to live in this facility. The resident stated they wanted to be placed in a group home specifically in Suffolk County because they thought they could be placed in a facility faster in Suffolk County. The resident stated they received psychological services when they had lived in their group home and talked about their feelings, and thoughts, and could talk to someone about what was bothering them physically, emotionally, and mentally. 10 NYCRR 415.15(b)(1)(i)(ii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 28173 Based on record review and interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for seven of seven units reviewed for the Sufficient Nursing Staffing Task. Specifically, 1) a review of the Payroll-Based Journal (PBJ) Staffing Data Report Quarter Three, 2024 (April 1- June 30) indicated excessively low weekend staffing and One Star Staffing Rating 2) a review of the daily staffing sheets revealed the facility did not provide sufficient numbers of Certified Nursing Assistants as indicated in the Facility Assessment. This is a repeat deficiency. The finding is: The Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Three, 2024 (April 1- June 30) indicated the facility triggered for excessively low weekend staffing and One Star Staffing Rating. The Facility Assessment, last updated June 2024, documented the average daily census was 265-275 residents. The facility consisted of seven resident units. The Facility Assessment indicated staffing plan for the weekends as follows: -Unit 1 East: During the 7:00 AM-3:00 PM Shift there should be three Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be two Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be two Licensed Practical Nurses and three Certified Nursing Assistants available. -Unit 2 East: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be 1.5 Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be one Licensed Practical Nurses and two Certified Nursing Assistants available. -Unit 2 West: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be 1.5 Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be one Licensed Practical Nurses and two Certified Nursing Assistants available. -Unit 3 East: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be two Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be 1.5 Licensed Practical Nurses and three Certified Nursing Assistants available. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unit 3 West: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be two Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be 1.5 Licensed Practical Nurses and two Certified Nursing Assistants available. -Unit 4 East: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be two Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be 1.5 Licensed Practical Nurses and three Certified Nursing Assistants available. -Unit 4 West, the Dementia Unit: During the 7:00 AM-3:00 PM Shift there should be 2.5 Licensed Practical Nurses and five Certified Nursing Assistants available. During the 3:00 PM-11:00 PM shift there should be two Licensed Practical Nurses and four Certified Nursing Assistants available. During the 11:00 PM-7:00 AM shift there should be 1.5 Licensed Practical Nurses and three Certified Nursing Assistants available. A review of weekend staffing sheets for April 2024 through June 2024 and during the Recertification Survey the facility was had low staffing levels based on the numbers specified in the Facility Assessment. The staffing concerns were identified including but not limited to the following: During the 7:00 AM to 3:00 PM Shift: -Unit 1 East had one Licensed Practical Nurse assigned on 4/6/2024, 5/5/2024, 5/12/2024, 6/15/2024, and 6/23/2024. -Unit 2 East had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/15/2024, and 6/23/2024. -Unit 2 [NAME] had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, and 6/23/2024. -Unit 3 East had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/15/2024, and 6/23/2024. -Unit 3 [NAME] had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/25/2024, 6/1/2024, 6/2/2024, and 6/15/2024. -Unit 4 East had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/15/2024, and 6/23/2024. - Unit 4 west had one Licensed Practical Nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/15/2024, and 6/23/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Commons Care Center Inc	60 Merrick Avenue East Meadow, NY 11554

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the 7:00 AM to 3:00 PM Shift: -Unit 1 East had three Certified Nursing Assistants on 4/14/2024, -Unit 2 East had three Certified Nursing Assistants on 6/9/2024, -Unit 2 [NAME] had three Certified Nursing Assistants on 4/7/2024, 4/13/2024, 6/2/2024, 6/8/2024, -Unit 3 [NAME] had three Certified Nursing Assistants on 4/28/2024, 6/9/2024, -Unit 4 East had three Certified Nursing Assistants on 4/13/2024, 4/28/2024, 6/2/2024, - Unit 4 west had three Certified Nursing Assistants on 4/6/2024, During an interview on 12/23/2024 at 2:35 PM, the Staffing Coordinator stated the facility has staffing shortage on the weekends for a long time. The Staffing Coordinator stated the facility utilizes one agency; however, the staffing issues have not been resolved. The Staffing Coordinator stated they have informed both the Director of Nursing Services and the Director of Human Resources with no resolution. During an interview on 12/23/2024 at 2:53 PM, the Director of Nursing Services stated they were not familiar with the Payroll-Based Journal or that the facility triggered for the low weekend staffing on the Payroll-Based Journal. The Director of Nursing Services stated the Facility Assessment is updated by them and the Administrator. The Director of Nursing Services acknowledged the facility had staffing concerns on weekends because the facility has not been successful in hiring enough staff for the weekends despite their efforts and has been challenged with a high staffing turnover rate. During an interview on 12/23/2024 at 3:30 PM, the Administrator stated the facility is committed to meeting the staffing levels identified in the Facility Assessment; however, they have been unsuccessful in doing so at this time which because of difficulty in attracting and retaining nursing staff. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732 Based on record review and staff interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not ensure each resident received the necessary behavioral health care and services according to the resident's comprehensive assessment and plan of care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This was identified for one (Resident #93) of four residents reviewed for Choices. Specifically, Resident #93 was not offered behavioral or psychological counseling when the resident expressed feeling down, depressed, and hopeless to Social Worker #1. Additionally, the Psychiatrist's consultation dated 10/21/2024 recommended providing behavior therapy. Nurse Practioner #1 reviewed the recommendations provided by the Psychiatrist; however, did not agree, disagree, or implement the recommendations. The finding is: The Consultation Policy and Procedure, last reviewed in January 2024 documented the Physician will approve any orders they agree with on the consultation. The Physician will document the reason if they disagree with the consultant. Resident #93, who has no known family or designated representative, has diagnoses that include Schizophrenia, Anxiety Disorder, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The Minimum Data Set assessment documented Resident #93 was feeling down, depressed, hopeless, had trouble falling or staying asleep, had little energy, felt bad about themselves, and had trouble concentrating on things. The assessment documented Resident #93 received Antipsychotic and Antidepressant medications during the 7-day lookback period. The Level I Preadmission Screening and Resident Review (PASRR) Screen dated 2/29/2024 documented that Resident #93 had a serious mental illness and required a referral for Level II evaluation by the designated mental health review entity. The Preadmission Screening and Resident Review (PASRR) Level II Screen dated 3/12/2024 documented Resident #93 had a diagnosis of Schizophrenia, Anxiety Disorder, Depressive Disorder, and Bipolar Disorder. The screen documented the nursing facility was required to provide Resident #93 with a person-centered psychiatric plan of care, ongoing psychiatric consultations, medication management by a Psychiatrist or licensed prescriber, recovery-oriented clinical counseling focused on goal achievement by overcoming mental illness barriers, and therapeutic group interventions. The screen documented Resident #93 would benefit from professional counseling to help process feelings within a supportive setting and help learn healthy coping skills to calm themselves when experiencing difficult emotions. The counseling can effectively address the resident's symptoms which include sadness, worry, and Paranoia (a mental state where a person has an irrational and persistent fear of being harmed or deceived by others). The screen documented Resident #93's symptoms led to the need for ongoing psychiatric care and medication management and it is likely Resident #93's daily life has been impacted by the mental illness. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Psychiatry Consultation dated 10/21/2024 documented the resident felt unhappy, lonely, and had no primary support. Recommendations were for the resident to receive behavior therapy or counseling. The Physician's Consult Review Note dated 10/22/2024, written by Nurse Practitioner #1, documented they reviewed the Psychiatry Consultation dated 10/21/2024. Nurse Practitioner #1 rewrote all the recommendations made by the Psychiatrist in the Psychiatry Consultation dated 10/21/2024; however, Nurse Practitioner #1 did not document whether they agreed or disagreed with the recommendations. A review of Resident #93's Physician's Orders revealed no orders for behavior therapy or counseling. The Care Plan Notes (progress note) dated 11/20/2024, written by Social Worker #1, documented the resident displayed or reported the following: Feeling down, depressed, hopeless, tired, or having little energy. Sleep pattern issues: trouble falling asleep or sleeping too much. The resident has a diagnosis of Anxiety and Depression. The was admitted with a Level 2 PASRR evaluation indicating serious mental illness including Bipolar Disorder, Schizophrenia, Anxiety Disorder, and Depressive Disorder. The Care Plan Meeting Progress Note dated 11/20/2024, written by Social Worker #1, documented Resident #93 had no family contact and the resident was not able to represent themselves due to periods of confusion. The Interdisciplinary Team members present for a quarterly care plan meeting were Social Worker #1 and a representative from the Dietary Department. The resident's plan of care was reviewed and all concerns were addressed. The resident would remain in the facility for long-term care. A review of the resident's Electronic Medical Record on 12/17/2024 at 11:30 AM revealed no documented evidence that Resident #93 was referred to behavior therapy or counseling services by the Social Worker. During an interview on 12/17/2024 at 12:30 PM, the assigned Social Worker #1 stated Resident 93's Brief Interview for Mental Status score was 13; however, Resident #93 was not invited to their care plan meeting, because the resident was confused at times. Social Worker #1 stated Resident #93 had reported feeling down, depressed, and hopeless and Social Worker #1 reported the resident's mood to the nursing staff (could not recall who); the nursing staff was supposed to report and obtain Physician's orders for behavior counseling. Social Worker #1 stated they did not document their communication with the nursing staff in the resident's medical record. During an interview on 12/17/2024 at 1:50 PM, the Director of Social Services stated after Social Worker #1 asked Nursing staff to obtain a Physician's Order for the resident to receive behavioral or psychological counseling, Social Worker #1 should have documented the conversation and followed through and made sure a Physician's Order was obtained for counseling services. During an interview on 12/17/2024 at 3:20 PM, the Administrator stated Social Worker #1 should have ensured a physician's order for psychological services was in place to address the resident feeling down, depressed, and hopeless and documented the interventions they put in place. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 5:00 PM, Nurse Practitioner #1 stated they were a remote (does not physically work in the facility) Medical Provider who only reviews the recommendations made by the Psychiatrist. Nurse Practitioner #1 stated they had strict instructions from their Supervisor to not write Physician Orders. Nurse Practitioner #1 stated the in-house Medical Providers are the ones to either agree or disagree with the recommendations made by the Psychiatrist. Nurse Practitioner #1 stated if an in-house Medical Provider agrees with the recommendations made by the Psychiatrist, they would be the one to place the Physician's Orders in the resident's Electronic Medical Record. During an interview on 12/17/2024 at 5:25 PM, the resident's Primary Physician (Primary Physician #1) stated a remote Medical Provider can also enter Physician's Orders in the resident's Electronic Medical Record after reviewing a resident's Psychiatry Consultation. Primary Physician #1 stated that a resident can not receive behavioral (Psychological) counseling without a Physician's Order. Primary Physician #1 stated they were not aware of the Psychiatrist's recommendation for Resident #93 to receive behavioral counseling. During an interview on 12/17/2024 at 6:00 PM, the Medical Director stated that whenever a Medical Provider, either remote or in-house, reviews a Psychiatry Consultation they are to document whether they agree or disagree with the recommendations. The Medical Director stated Nurse Practitioner #1 should have entered a Physician's Order into the resident's Electronic Medical Record for the resident to receive behavioral (Psychological) counseling services. During an interview on 12/18/2024 at 10:00 AM, the resident stated they had lived in a group home before coming to live in this facility. The resident stated they wanted to be placed in a group home specifically in Suffolk County because they thought they could be placed in a facility faster in Suffolk County. The resident stated they received psychological services when they had lived in their group home and talked about their feelings, and thoughts, and could talk to someone about what was bothering them physically, emotionally, and mentally. 10 NYCRR 415.12(f)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on observations, record review, and interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/23/2024, the facility did not ensure that drug records were in order and accounted for all controlled drugs. This was identified on one (Unit 1 East) of seven units reviewed during the Medication Storage Task. Specifically, the Pharmacy delivered 56 tablets of Oxycodone 10 milligrams for Resident #162 on 12/17/2024; however, the Individual Resident's Controlled Substance Record documented that 46 tablets were received. Additionally, on 12/18/2024, the Individual Resident's Controlled Substance Record documented that 41 tablets of Oxycodone 10 milligrams were available, although the blister packs contained 50 tablets due to an inaccurate reconciliation of the total medication received from the Pharmacy on 12/17/2024. The finding is: The facility policy titled Controlled Substance/Narcotic Management Protocol dated 2/2021 and revised 1/2024 documented that all narcotics will be counted and reconciled at the beginning of every shift with the outgoing and oncoming nurse. Both nurses must sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift. Any discrepancies in the count must be reported to the unit manager and the nursing supervisor immediately. Staff responsible for narcotic administration will not leave their shift until the narcotic count is reconciled. Resident #162 was admitted with diagnoses including Pain, Osteomyelitis of the Sacral and Sacrococcygeal (tailbone) Region, and Stage 4 Pressure Ulcer. The Quarterly Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident received a scheduled pain medication regimen and did not have pain within the last 5 days. A Comprehensive Care Plan titled Alteration in Comfort dated 9/7/2023 and revised 2/6/2024 documented interventions including administering medications as ordered, monitoring, and documenting for side effects of pain medications. A Physician's Order effective 12/16/2024 documented Oxycodone 10 milligrams tablet; give one tablet by mouth every 6 hours for moderate to severe pain for 14 days. The Medication Administration Record for December 2024 documented the resident received each dose of Oxycodone 10 milligrams tablet as per the physician's orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit 1 East's Medication Storage Room was observed with Licensed Practical Nurse #4 on 12/18/2024 at 1:32 PM. Resident #162's Individual Resident's Controlled Substance Record for Oxycodone 10 milligrams documented 46 tablets were received from the Pharmacy on 12/17/2024. The Individual Resident's Controlled Substance Record documented that 41 Oxycodone 10 milligram tablets were remaining at 6:00 AM on 12/18/2024. There were two blister packs of Oxycodone 10 milligrams labeled with Resident #162's name. One of the two blister pack labels indicated 26 of 56 tablets were delivered by the Pharmacy. There were 20 tablets present in that blister pack. The second blister pack label indicated that 30 of 56 tablets were delivered by the Pharmacy. There were 30 tablets present in that blister pack for a total of 50 tablets remaining in the two blister packs. During an interview on 12/18/2024 at 1:33 PM, Licensed Practical Nurse #4 stated they prior to today, they were not aware of the observed discrepancy and that they were not the assigned medication nurse for Resident #162. During an interview on 12/18/2024 at 2:01 PM, Licensed Practical Nurse #5 stated they administered medication to Resident #162 on 12/18/2024 during the day shift. They reconciled the controlled substances for the residents with the outgoing night-shift Licensed Practical Nurse #6 on the morning of 12/18/2024 and did not notice any discrepancy. Licensed Practical Nurse #5 stated the Individual Resident's Controlled Substance Record documented that 46 tablets were received from the Pharmacy; however, the accurate number should have been 56 tablets and no one noticed the discrepancy including themselves. Licensed Practical Nurse #5 further stated they administered a dose of Oxycodone to Resident #162 at lunchtime on 12/18/2024 and forgot to update the Individual Resident's Controlled Substance Record. During an interview on 12/18/2024 at 2:34 PM, Licensed Practical Nurse #6 stated they worked the previous night shift from 11:00 PM to 7:00 AM and reconciled the Individual Resident's Controlled Substance Record with Licensed Practical Nurse #5. Licensed Practical Nurse #6 stated they may have overlooked the number of tablets available. During an interview on 12/18/2024 at 2:49 PM, the Assistant Director of Nursing Services stated the total amount of Oxycodone tablets that were received for Resident #162 from the Pharmacy was documented incorrectly. This discrepancy should have been picked up by the unit nurses immediately and the nursing supervisor should have been notified. Licensed Practical Nurse #5 should have updated the controlled substance record at the time of the medication administration. During an interview on 12/18/2024 at 3:53 PM, the Director of Nursing Services stated when a controlled substance is delivered by the Pharmacy, the nursing supervisor and the unit nurse, who receives the controlled substance, must ensure the accuracy of the amount and correctly document the amount on the Individual Resident's Controlled Substance Record for accurate reconciliation. The discrepancy for Resident #162's Oxycodone should have been picked up by the unit nurses and reported to the unit supervisor. 10 NYCRR 415.18(b)(1)(2)(3)