STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335389	A. Building B. Wing	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40568 Based on record review and interview during an abbreviated survey (Case #'s NY00299681 and NY00298816), the facility did not ensure residents were treated with dignity and respect in an environment that maintained or enhanced their quality of life and did not ensure residents were allowed to exercise their right to file a grievance, including the right to file an anonymous grievance, without interference, coercion, discrimination, or reprisal from the facility for 3 (North, South, and East Units) of 3 units. Specifically, the facility did not ensure residents were treated with dignity and respect when concerns were raised in Resident Council for 3 consecutive months regarding the professionalism of staff and staff yelling at residents. Additionally, the facility did not ensure grievance forms were easily accessible to residents in order to anonymously file a grievance without having to request a form from Resident and Family Services. This is evidenced by: Finding #1: The facility did not ensure residents were treated with dignity and respect when staff used inappropriate language in resident areas on the unit and Resident Council minutes for 3 consecutive months documented concerns regarding staff professionalism. The Policy and Procedure Resident Rights dated 7/2022, documented the basic right of a nursing home resident was to be treated with dignity and respect. An attached Right Summary documented residents had the right to be treated with dignity and respect and residents have the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment. The nursing home must address the issue promptly. Resident Council Minutes dated 6/13/2022 documented Professionalism when doing patient care and Staff discussing issues with coworkers in front of residents. Resident Council Minutes dated 7/26/2022, documented staff bashing other people in front of residents. Resident Council Minutes dated 8/22/2022, documented residents getting yelled at by staff (opposed to being talked to). The Resident Council Attendance sheet documented 17 residents from North Unit, 8 residents from East Unit and 4 residents from South Unit. (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 - Some	During an interview on 9/19/2022 at 11:33AM, Resident #9 stated the Resident Council reported that staff use inappropriate language, including the F-Bomb, have inappropriate behavior, and lack professionalism. Resident #9 stated staff expressed their aggravation to the residents and stated if the staff were going to vent, they needed to work and vent at the same time. Often, staff expressed their frustrations to the resident, and it would take up 10 of the 15 minutes of care the resident was supposed to receive. The resident stated we understand their job is frustrating, but we also need care. Resident #9 stated it was offensive to hear the F-word used by staff and it was unnecessary. The resident stated the staff usually swore when a resident rang the call bell one too many times. The resident could hear staff say, What the h--- do they want now, or it's F---ing (resident name) again. The resident stated staff are frustrated and aggravated, but the use of inappropriate language was not a rare occurrence. It was daily and that was why the resident brought it up in Resident Council. It needed to stop but was still unresolved. The Resident Council had no idea if the facility was working on a resolution for staff's lack of professionalism and how they talk to residents or within earshot of the residents. The resident stated that Resident Council were not informed on what happened with the staff or if they've been re-educated. During an interview on 9/19/2022 at 11:50 AM, Resident #11 stated they found it offensive to hear the F-word every day coming from the hallway, or behind the nurse's station. Resident #11 did not understand why the residents had to hear that and why staff could not go in a break room or off the unit to use that kind of language. The resident stated they heard staff say, What the h--- does (named resident) want now, F---ing (named resident) again on the call bell and what the f--- does (resident name) want. Resident #11 stated they did not think that was appropriate for staff to be saying those kinds of things every day for residents to hear. The resident stated staff swore and were unprofessional when they became frustrated. The resident stated they attended Resident Council on occasion, and it was reported at Resident Council about the staff swearing and using unprofessional language, but the staff behavior continued. During an interview on 9/19/2022 at 12:13 PM, the Administrator stated they had been made aware staff were short with residents but was not aware staff had yelled or sworn in the presence of residents. The Administrator stated they would keep doing education and if they found staff that were consistently not nice to residents, they needed to go. The Administrator stated people were short with each other at times, but the expectation was professionalism no matter how frustrated or tried the staff were. During an interview on 9/19/2022 at 11:57 AM, the Recreational Director (Rec Dir) stated they assist the residents in running Resident Council and had run 2 Resident Councils since being employed at the facility. The Rec Dir stated they had heard that the residents said the staff could be unprofessional and say rude things. The Rec Dir stated they sent emails to the Department Heads for them to get back to the Rec Dir on how to fix the issues but did not know if the Director of Nursing had gotten back to them about the professionalism of staff. Once the Rec Dir received a response from the Nursing Administration, they would get back to the residents with a response. The issue Resident Council reported was that staff were rude and staff did not explain things to the residents, and that it was not necessarily what the staff said but how they said it that was the problem. Finding #2: The facility did not ensure grievance forms were easily accessible to residents in order to anonymously file a grievance without having to request a form from Resident and Family Services. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Policy and Procedure titled Grievance Reporting and Response dated 7/1/2022, documented to make a complaint or a recommendation, fill out a grievance form and give it to the Director of Social Services or put it in the grievance box located by the Social Work office. Grievances could also be filed verbally with the Director of Social Work or the Administrator. Grievances may be named or anonymous when put in the drop box. Resident Council Minutes dated 7/26/2022, documented to talk to Social Work about how to go about filing grievances (appointments or not). During an interview on 9/14/2022 at 11:20 AM, Resident #3 stated in order to file a grievance the Social Worker (Director of Social Services) has to bring a form down to their room. The residents could not get the forms themselves. They had to ask for a grievance form to fill it out. During an interview on 9/19/2022 at 11:33 AM, Resident #9 stated the residents had to get grievance forms from the Director of Social Services. Resident #9 stated if residents wanted to file a grievance they would have to ask for a form. The forms were not available on the unit for residents' access. During an interview on 9/14/2022 at 4:45 PM, the Director of Resident and Family Services (DRFS) stated grievance forms were in the Social Work office and to their knowledge, the forms were not kept where residents had access to them to file grievances anonymously. The DRFS stated they could see why residents would be hesitant to file grievance if they could not do it anonymously. Upon review of the Resident Council minutes from July 2022, the DRFS stated appointments were not needed to file a grievance and the resident could ask for a form anytime. During an interview on 9/19/22 at 12:13 PM, the Administrator stated they were in the process of revising the process for grievances to ensure the forms were looked at regularly. The Administrator stated they needed someone to take charge of the grievance forms and right now, the Administrator was reading the grievance forms until they decided who would take charge of the grievances. The Administrator stated the grievance forms should be on every unit and they told the Director of Resident and Family Services last week to make sure there were grievance forms on each unit, and to label the boxes for the grievance forms on each unit. 10NYCRR 415.5(a)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40348 Based on record review and interview during an abbreviated survey (Case #NY00299861), the facility failed to ensure all residents were free from abuse, neglect, and mistreatment when allegations of sexual abuse by Resident #4 were reported. Specifically, on 7/26/2022 at 1:30 AM, Certified Nursing Assistant (CNA) #3 observed Resident #4, who had severely impaired cognition, standing next to the bedside of Resident #2, who had moderately impaired cognition. Resident #2's sheets were off and hospital gown was pulled up. CNA #3 removed Resident #4 from the room. On the same day, 7/26/2022 at 4:45 AM, Resident #4 wandered into the room of Resident #3, who was cognitively intact and reported to CNA #3 and Registered Nurse (RN) #1 that they were sexually assaulted by Resident #4. Resident #3 stated they woke up to Resident #4 fondling their breast and inner thigh. Resident #3 has a history of Post-Traumatic Stress Disorder (PTSD) after being sexually assaulted as a child and reported experiencing increased anxiety as a result of this incident with Resident #4. As a result, the facility did not collect evidence to determine what occurred or what actions or systems were necessary to prevent sexual abuse by Resident #4 from reoccurring and failed to provide a safe environment to residents. This resulted in, or had the likelihood for, psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care to resident health and safety and had the likelihood to affect all residents in the facility. The Immediate Jeopardy was lifted on 9/16/2022. This is evidenced by: The Policy and Procedure (P&P) titled Resident Abuse Prevention and Reporting dated 5/2022, documented that all residents would be treated with respect and dignity, would be free from abuse, and all residents would be protected and provided a safe environment. The Nursing Home Incident Intake Form dated 7/27/2022 at 9:38 AM, documented on 7/26/2022 at 4:45 AM, it was reported Resident #4 had gone into Resident #2 and Resident #3's rooms and touched them inappropriately. The investigation was on-going, and the facility's immediate response was to continue 15-minute checks with close supervision. Incident #1: On 7/26/2022 at 1:30 AM, the facility failed to implement interventions to maintain the safety of all residents after Certified Nursing Assistant (CNA) #3 observed Resident #4 standing next to the bedside of Resident #2. Resident #2's sheets were off and hospital gown was pulled up. CNA #3 removed Resident #4 from the room. Resident #4: Resident #4 was admitted with diagnoses of dementia, stroke, and Parkinson's disease. The Minimum Data Set (MDS- an assessment tool) dated 5/7/2022, documented the resident had severely impaired cognition, could usually understand others, and could usually make themselves understood. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Comprehensive Care Plan (CCP) for Activities of Daily Living, last revised 5/2/2022, documented Resident #4 required intermittent supervision without an assistive device throughout the facility for ambulation and was independent with transfers and toilet use. The CCP did not include person centered care plans with individualized interventions to ensure Resident #4 was supervised and monitored by staff due to the resident's history of wandering on the unit and in and out of other residents' rooms. A care plan for wandering was initiated on 8/2/2022. Resident #2: Resident #2 was admitted with diagnoses of lung disease, bipolar disorder, and stroke. The Minimum Data Set (MDS- an assessment tool) dated 5/4/2022, documented the resident had moderately impaired cognition, could understand others, and could make themselves understood. The CCP for At Risk for Being Targeted, dated 4/25/2022, documented Resident #2 was at risk for being targeted physically or verbally by a co-resident secondary to impaired physical mobility. Interventions included: Observe for any co-resident ramping up and to remove the co-resident from harm's way immediately, and to seat/position the resident away from co-residents who were known to be aggressive to others. The CCP did not include person centered care plans with individualized interventions to ensure the safety of Resident #2's physical and psychosocial well-being related to the incident with Resident #4 on 7/26/2022 at 1:30 AM. The Incident and Accident report (I&A) dated 7/26/2022, initiated by Registered Nurse (RN) #1, documented Resident #4 had inappropriate contact with another resident (Resident #2). The immediate action to protect resident safety was to maintain 15-minute checks for Resident #4. Situational factors included: there was only one aide and one nurse on the unit for the duration of 11 PM - 7 AM shift. The RN documented the resident was last seen at 4:30 AM and was wandering into other resident rooms. A staff statement dated 7/26/2022 at 1:30 AM, written by CNA #3, documented Resident #4 was found in Resident #2's room near their bed. When CNA #3 walked into the room and asked what was going on, Resident #2 stated they were making love with Resident #4. Resident #2's sheets were off and hospital gown was pulled up. CNA #3 removed Resident #4 from the room. The CCP and physician orders for Resident #4 did not include an order for 15-minute checks. Progress notes documented on: -7/26/2022 at 1:21 AM, Resident #4 was awake and hovering around nursing station beginning of shift. Then began wandering and peering into other patients' rooms. When redirected Resident #4 stated they would not disturb the other residents. Resident #4 began entering rooms. The resident startled the resident in bed by the door and chose to keep returning to that room and became threatening to staff when they attempted to distract and remove Resident #4 from the room. -7/26/2022 at 1:28 AM, Resident #2 was awakened when another resident entered their room and had to be removed. Resident #2 began yelling help and when asked what they needed Resident #2 stated nothing and told staff to leave the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-7/26/2022 at 3:47 AM, Resident #4 would not remain in bed nor in their room. Resident was napping in chair by nursing station. There was one incidence of trying to enter someone's room and became threatening both verbally and physically brandishing their fists. Resident #4 returned to chair by the nursing station. -7/26/2022 at 6:17 AM, Resident #2 stated to the aide on duty that they were making 'love' with the Resident #4. -7/26/2022 at 8:32 AM, the Attending Physician was updated at 6:30 AM. -7/26/2022 at 8:35 AM, Resident #2 confided that they did not want Resident #4 to get into trouble. Resident #2 did not understand why they were not allowed to 'make love'. The Skin Observation Tool dated 7/26/2022 at 2:31 PM, documented Resident #2 did not have injuries or any bruised/open areas. The medical record for Resident #2 did not include a Registered Nurse (RN) Assessment to assess for physical and psychosocial harm after the incident with Resident #4 on 7/26/2022. During an interview on 9/14/2022 at 11:45 AM, RN #1 stated Resident #4 was wandering around the unit and in and out of residents' rooms on the night of 7/26/2022. Resident #4 was on 15-minute checks, but it would have been impossible for the RN to constantly keep an eye on Resident #4. The RN stated after the resident went into the room of Resident #2, there were no other interventions were implemented except to maintain the 15-minute checks that the resident was already on. During an interview on 9/14/2022 at 4:30 PM, the Director of Resident and Family Services (DRFS) stated they were not made aware of the incident between Resident #4 and Resident #2 on 7/26/2022. The DRFS stated that Resident #4 was at risk for elopement and that was why they had been on 15-minute checks prior to 7/26/2022. The DRFS did not know if the resident had a care plan for the 15-minute checks or a care plan to address the resident's wandering. The DRFS stated they were not responsible for investigating the incident or updating care plans of Resident #2 and Resident #4 after an incident. That was deferred to nursing. During an interview on 9/15/2022 at 10:27 AM, the Staffing Coordinator, who also worked as a CNA, stated when there was one nurse and one aide working on a unit and it would be impossible to do 15-minute checks on a resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a subsequent interview on 9/15/2022 at 11:10 AM, RN #1 stated the progress note on 7/26/2022 at 1:30 AM, was about Resident #4 being in Resident #2's room. Resident #4 was in Resident #2's room standing at beside the bed. The RN stated they observed Resident #4 was trying to climb into Resident #2's bed with one knee in air and their hands were on the bed supporting themself to get into the bed. The RN stated they told Resident #4 they were not supposed to be in the room and assisted the resident out of the room to the nursing station where the RN had a clear view of the resident. The RN stated at 6:00 AM on 7/26/2022, CNA #3 reported Resident #2 and Resident #4 had contact with each other. Resident #4 was reportedly fondling Resident #2. When the RN went in to talk to Resident #2 after that had been reported, Resident #2 stated to the RN that they were a couple with Resident #4 and the touching was not an issue. The RN was under the impression the two residents wanted to be together. The RN did not notify Administration until after 6:00 AM on 7/26/2022 of the incident because they did not know the resident's had contact with each other until the CNA #3 reported it at 6:00 AM. The RN stated they had found Resident #4 close to other residents when they wandered in and out of resident rooms. Resident #4 had the opportunity to touch other residents, but the RN did not know if Resident #4 had in fact touched other residents. The RN stated Resident #4's behaviors were inappropriate and dangerous. During an interview on 9/15/2022 at 11:50 AM, the Assistant Director of Nursing (ADON) stated RN #1 was supposed to call them or the Director of Nursing immediately after an incident occurred. The ADON stated their understanding of the incident was that CNA #3 was rounding and found Resident #4 in Resident #2's room on top of Resident #2 in the bed. When the ADON was asked further about Resident #4 being on top of Resident #2, the ADON stated well, maybe I have it wrong. The ADON stated it was reported that Resident #4 was standing next to Resident #2's bed. Resident #2's sheet was down, and their gown was up above their belly button, exposing their abdomen and incontinence brief. The ADON stated Resident #2 screamed at the CNA to get out because they were about to make love. The ADON stated they became aware of the incident with Resident #2 and #4 the next morning, but they should have been called by the RN immediately after it had happened. During an interview on 9/16/2022 at 11:46 AM, the Nurse Practitioner (NP) stated they knew Resident #4 had behaviors but was not told about the resident's wandering in and out of other resident rooms. The NP was not the on call the night of the incident with Resident #2 and Resident #4 and was not made aware of the incident. The NP stated the RN should have assessed the resident after the incident and called the provider at the time. The NP stated they knew that Resident #4 paid attention to Resident #2 and would push Resident #2 in their wheelchair. When the NP would see Resident #2 and Resident #4 sitting and holding hands, Resident #2 would say Resident #4 was their boyfriend. These interactions were seen in passing and were not documented. The NP stated that on 8/3/2022, Resident #2 asked for a room change so that Resident #4 could not find her. During an interview on 9/16/2022 at 1:20 PM, the Administrator stated the DON (define) informed them of the incident. Resident #4 was on 15 minutes checks but after the incident at 1:30 AM, the resident should have been assigned 1:1 supervision but was not. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/20/2022 at 2:30 PM, CNA #3 stated they did not know Resident #4 was a wanderer and stated I guess they were on 15-minute checks. The CNA stated on 7/26/2022 between 1:00 AM and 2:00 AM, they could not find Resident #4 and when they found the resident, they were in Resident #2's room. When CNA #3 saw Resident #4 on top of Resident #2 in Resident #2's bed, the CNA stated they turned the light on to make sure they were seeing what they thought they were seeing and saw that Resident #4 was on top of Resident #2 in the bed. Resident #4 was in between Resident #2's legs with both feet off the floor and fully on the bed on top of Resident #2. Resident #4 was pulling up Resident #2's gown above their belly button and Resident #2 was tugging at their incontinence brief in a motion to pull off the brief. The CNA stated they called to the RN they were working with that night and removed Resident #4 from Resident #2's room. Resident #2 became agitated and was cursing and saying they were interrupted. CNA #3 stated they reported it to RN #1 and RN #1 did not do anything different after this incident with Resident #4. Resident #4 was brought out the nurses' station but there were no new interventions put in place. The CNA stated later that same night, Resident #4 had another incident with a resident. Resident #3 reported they were touched by Resident #4. Incident #2: On the same morning, 7/26/2022 at 4:45 AM, Resident #4 wandered into the room of Resident #3 who reported to CNA #3 and Registered Nurse (RN) #1 that they were sexually assaulted by Resident #4. Resident #3 stated they woke up to Resident #4 fondling their breast and inner thigh. Resident #3 had a history of Post-Traumatic Stress Disorder (PTSD) after being sexually assaulted as a child and reported experiencing increased anxiety because of this incident with Resident #4. Resident #3: Resident #3 was admitted with post-traumatic stress disorder (PTSD), schizoaffective disorder, and respiratory failure with hypoxia. The Minimum Data Set (MDS- an assessment tool) dated 6/10/2022, documented the resident was cognitively intact, could understand others and could make themselves understood. The Comprehensive Care Plan (CCP) for Alteration in Psychosocial Well-being, last revised 9/6/2020, documented to attach a Velcro Stop Sign barrier to the door frame for the resident's feeling of safety and security. The Stop Sign intervention was dated 7/27/2022. The CCP did not include person centered care plans with individualized interventions to ensure the safety of Resident #3's physical and psychosocial wellbeing related to the sexual assault by Resident #4 on 7/26/2022. The Incident and Accident (I&A) report dated 7/29/2022, initiated by the Director of Nursing (DON) documented Resident #4 entered the room of Resident #3 without authorization. The I&A did not document the date and time of the incident. The immediate action to protect resident safety was that the wandering resident was placed on 15-minute checks and close supervision by the supervisor. A staff statement dated 7/26/2022 at 4:45 AM, written by RN #1, documented Resident #4 was due for their 15-minute check when Resident #3 told the RN that Resident #4 had touched Resident #3's breasts and was moving their hand down Resident #3's leg. Progress notes documented on: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-7/26/2022 at 4:45 AM, Resident #3 told RN #1 that Resident #4 had touched their breasts and moved their hand down to Resident #3's leg. -7/26/2022 at 8:25 AM, the Attending Physician was updated at 6:30 AM. -7/26/2022 at 10:20 AM, Resident #4 remained on 15-minute checks, continued to wander in the hallway and peer into rooms. The resident was redirected many times and will continue to monitor. -7/26/2022 at 2:45 PM, Resident #3 continued to talk in calm manner to few staff and residents about incident. The resident requested as needed (prn) hydroxyzine (antihistamine used to treat anxiety) in the morning with effect. -7/26/2022 at 10:52 PM, Resident #4 was wandering all over in other residents' rooms. The resident did not respond at first when redirected out of room. The resident had to be told again and guided out. The other residents were upset. -7/26/2022 at 11:20 PM, Resident #3 mentioned the other resident (Resident #4) at end of the shift. Resident #3 expressed anxiety and was given Atarax (hydroxyzine). The resident's representative called and was concerned for Resident #3's safety. -7/27/2022 at 10:40 AM, the Nurse Practitioner (NP) documented Resident #3 had a recent episode with a resident with dementia also increasing the resident's anxiety. Resident #3 had previously refused/stopped using their Stop Sign across doorway and was now using it and allowed staff to place it across their door. -7/29/2022 at 10:48 AM, Resident #3 still concerned over past incident and will reach out to mental health today. The medical record did not include documentation the facility assisted the resident with obtaining psychological or psychiatric services after the incident on 7/26/2022. The Skin Observation Tool completed on 7/26/2022 at 2:36 PM, documented Resident #3 had no injury, no bruising, and no open areas on their body. The medical record did not include a Registered Nurse (RN) Assessment to assess for physical and psychosocial harm after the alleged incident with Resident #4 on 7/26/2022. The facility did not notify law enforcement of the alleged sexual assault. During an interview on 9/14/2022 at 11:00 AM, Resident #3 stated on 7/26/2022 at 4:45 AM, they were sleeping and woke up to Resident #4 standing next to their bed close to the side rail of the bed. Resident #3 stated Resident #4 had their hand under Resident #3's gown and was rubbing their breast and Resident #4's other hand was rubbing Resident #3's upper thigh toward their private area. Resident #3 stated they rang their call bell and CNA #3 came in and removed Resident #4. CNA #3 called for RN #1. Resident #3 stated CNA #3 said not again when removing Resident #4. Resident #3 stated the next day staff put up a stop sign on their bedroom door. (continued on next page)

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Livingston Hills Nursing and Rehabilitation Center	2781 Route 9 Livingston, NY 12541

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/14/2022 at 11:45 AM, RN #1 stated at 4:45 AM on 7/26/2022, Resident #4 was found in the Activity Room next to Resident #3's room. Resident #4 was wandering around in and out of rooms during the night and RN #1 stated they did not know what to do with the resident. The RN stated there were no other interventions implemented in addition to Resident #4 already being on 15-minute checks after the initial incident with Resident #2 and nothing else was implemented after the incident with Resident #3. RN #1 stated Resident #3 told them what happened with Resident #4 and after that the RN kept the resident up by the nurses' station and was more aware of where the resident was for the remainder of the shift. The RN stated Resident #4 was quick and went room to room when they were wandering. RN #1 stated they did not complete a physical assessment of Resident #3 and the resident did not seem to be shaken up at the time. RN #1 stated they did not put a stop sign up on Resident #3's door after the incident was reported to them. The RN called administration in the morning and did not report the incident right after it happened. During an interview on 9/15/2022 at 11:50 AM, the Assistant Director of Nursing (ADON) stated they became aware of the incident with Resident #3 and Resident #4 the next morning. The ADON stated they saw Resident #3 that morning and did not do an assessment, did not start an investigation, and did not initiate a care plan for either resident. During an interview on 9/15/2022 at 3:25 PM, the Director of Nursing (DON) stated RN#1 did not notify them of the incident immediately after it happened, and they wished they had been called at the time of the incident because they would have instructed the RN #1 to implement a 1:1 with Resident #4. The DON stated they would have come in to do the 1:1 themselves if there were not staff in building to do it. The DON stated the RN did not start a care plan and should have. The DON stated the Nurse Practitioner (NP) went to assess the Resident #3 the next day and the DRFS was also supposed to see the resident. The DON stated after the incident a care conference was held for Resident #4 on 7/30/2022 to discuss a room change, but the family did not want the resident moved to South Unit, the designated dementia unit. During an interview on 9/16/2022 at 11:46 AM, the NP stated they heard about the incident the next day and had physically assessed Resident #3 with no findings. The NP assessment was not documented. Resident #3 had reported to the NP that Resident #4 walked into their room and thought the resident had touched them. Resident #3 stated they were ok but did not want Resident #4 in their room. The NP stated Resident #3 had reported an increase in anxiety related to the incident with Resident #4 and Resident #3 had a history of PTSD and sexual assault. The NP stated they were not the attending provider for the North Unit, but if they had been notified of the incident, they would have sent Resident #3 out to the hospital for evaluation and placed Resident #4 on a 1:1 or continued the 15-minute checks. The NP stated, but with 15-minute checks you have to think to yourself what the resident is doing with the 14 minutes in between each 15-minute check. The NP stated immediate interventions should have been implemented to keep Resident #4 safe and the other residents safe. The NP stated the RN should have assessed Resident #3 after the incident and called the provider at the time. Law enforcement was not called according to the NP's knowledge. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/16/2022 at 1:20 PM, the Administrator stated Resident #4 was on 15 minutes checks but after the incident at 1:30 AM, Resident #4 should have been assigned a 1:1 for supervision. At 4:45 AM, Administration should have been called immediately after Resident #3 reported Resident #4 touched them. If Administration had been called, they would have given the staff direction. The RN should have assessed the resident and written a note. The Administrator stated they read in the progress notes after the incident and realized then Resident #3 had increased anxiety and the psych referral should be made. The DRFS should have been involved after the incident. The Administrator stated Resident #4 should have been placed on 1:1 and the 1:1 would have continued until the next day and would not have been removed until the resident was reassessed and was moved to South Unit. During an interview on 9/16/2022 at 4:19 PM, Licensed Practical Nurse (LPN) #11 stated there was no set plan for Resident #4 and they wandered at will. The resident wandered into rooms and would just stand there or use the other residents' bathrooms. Resident #4 would go in any room. LPN #11 stated they saw Resident #3 after the incident on 7/26/2022 but did not write a note. LPN #11 stated Resident #3 said that Resident #4 had touched them, and the supervisor had taken care of it, but Resident #3 was upset. Resident #3 talked about how it brought back past trauma that they had, and they were scared. Resident #4 remained on 15-minute checks, and Resident #3 had a stop sign put up in their doorway. Prior to the incident, Resident #3 had a stop sign because Resident #4 would wander down there. LPN #11 had told Resident #3 to contact their mental health provider as the resident had their direct number. During an interview on 9/20/2022 at 2:30 PM, CNA #3 stated Resident #3 reported Resident #4 touched them. Resident #3 became very upset and called their family because they were scared. The resident stated that Resident #4 felt them up. Resident #4 touched Resident #3's thigh and the CNA stated they thought the resident reported their breast was also touched. The CNA went to check on Resident #3 and the resident was distraught and crying. The CNA and RN put the stop sign barrier up on the resident's door. The CNA stated after this incident, Resident #4 was not placed on a 1:1. The resident remained on 15-minute checks. Incident #3: On 8/4/2022, Resident #4 had unwanted contact with Resident #3. During an interview on 9/15/2022 at 5:40 PM, Resident #3 stated on 8/4/2022 they were wheeling down the hallway in their wheelchair and Resident #4 had their arm extended with their hand on Resident #2's shoulder. Resident #3 stated that they could not get by and said excuse me and tried to go around both of them. Resident #4 put their hand on Resident #3's shoulder to prevent them from going around. Resident #3 stated they pulled away and then Resident #4 punched them in the left forearm leaving a bruise. The resident stated they reported this to a nurse who wrote said they would file a grievance on it. The facility did not provide an Investigation, I&A report, or grievance form for the alleged physical incident on 8/4/2022 involving Resident #3 and Resident #4. Progress notes documented on: -8/3/2022 at 2:15 AM, Resident #4 continued on every 15-minute checks for safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-8/3/2022 at 11:38 PM, the NP documented Resident #4 had increasing behaviors and observed reaction/behavior to delusions related to another resident (Resident #2) they believed to be their spouse. Redirection was occasionally effective, but as the delusion increased in intensity, Resident #4 was less likely to be redirected and was becoming more aggressive. The other resident (Resident #2) had confided they were not comfortable with keeping company and asked for a room change so Resident #4 could not visit them. Resident #4 was observed wheeling the other resident in their wheelchair while they were objecting. Staff and this writer intervened on numerous occasions. Room change to be accommodated to provide security to the other resident. Room change to take place in the morning. -8/4/2022 at 5:12 PM, Resident #4 was being physically assaultive and verbally aggressive. Resident #4 became attached to another resident and taken on a protector role. The NP was notified and ordered that a 1x dose of Haldol (antipsychotic medication) for Resident #4. After the nurse retrieved the medication from the emergency kit, the resident was trying to get back to the aforementioned resident and again attempted to punch staff. Family agreed to allow the facility to move Resident #4 to South Unit tomorrow which will hopefully be less overstimulating. -8/10/2022 at 9:31 PM, Resident #4 was wandering in and out of other residents' rooms and going through their things. When redirecting the resident, they became very combative towards staff and redirection ineffective. Resident #4's behavior continues. -8/11/2022 at 10:40 PM, Resident #4 was wandering in and out of residents' rooms. At one point, Resident #4 was attempting to get into other residents' beds with them in it. Redirection was very difficult as the resident became very agitated and striking out. Resident #4 wandered to the North Unit several times and again, it was difficult to assist them back to (South) unit. Resident #3's medical record did not include documentation of the alleged unwanted physical contact with Resident #4 on 8/4/2022. Resident #3's medical record did not include a completed Skin Observation Tool or a Registered Nurse Assessment to assess for physical and psychosocial harm after the alleged incident with Resident #4 on 8/4/2022. During an interview on 9/14/2022 at 1:40 PM, Licensed Practical Nurse (LPN) #1 stated they had no idea there had been an alleged sexual assault involving Resident #4. The LPN stated they knew Resident #4 had been moved to South Unit due to escalated behaviors. On North Unit, Resident #4 had gotten the other residents upset by going in and out of their rooms. The LPN's fear was that there would be a confrontation when Resident #4 went into other residents' rooms and because Resident #4 did not know boundaries. The LPN stated there were no appropriate interventions implemented for Resident #4 to keep them safe or other resident's safe. The LPN stated even when there were 2 CNAs and 1 LPN on the unit, it was impossible to do 15-minute checks on Resident #4. The CNAs would be providing care to residents behind closed doors and the nurse would be passing medications. No one could see where Resident #4 was. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/14/2022 at 4:30 PM, the Director of Resident and Family Services (DRFS) stated a care plan for Resident #4's wandering was not updated and there were no interventions in place for the resident's wandering other than 15-minute checks. The interdisciplinary team had a care plan meeting on 7/30/2022 with Resident #4's family and it was discussed that the resident would be transferred to the South Unit as it would be more appropriate given the resident's recent behaviors. Resident #4's family did not want the resident transferred off North Unit. The DRFS stated Resident #4 did not get moved off North Unit at the family's request and the decision not to move the resident put the rest of the residents at risk. The DRFS stated on 8/4/2022, the family of Resident #3 called them and told them that there had been a repeat incident with Resident #4. The DRFS was not sure what a repeat incident meant but the DRFS was on their way to give Resident #3 a grievance form to report the repeat incident with Resident #4 when DRFS was distracted by Resident #2 who was screaming. The DRFS stated Resident #4 wheeled Resident #2 outside and Resident #2 did not want to go so they were screaming. The DRFS did not follow up with Resident #3 about the alleged unwanted contact on 8/4/2022, did not file a grievance for the resident, and did not notify Administration on 8/4/2022. DRFS stated Resident #4 was moved to South Unit on 8/5/2022, due to the incident with Resident #2 screaming, not because of the reported 2nd incident with Resident #3. During an interview on 9/15/2022 at 3:45 PM, the DON stated they were aware there was another incident on 8/4/2022 with Resident #3 and Resident #4 but was made aware after the fact. They did not complete an A&I report after finding out or investigate it further. The DON did not know about the alleged bruise. The DON just knew that an incident took place between the 2 residents. The DON stated the facility did not move Resident #4 to the South Unit before 8/5/2022 because family kept refusing. The facility should not have appeased the family and the resident should have been moved due to their behaviors. The DON stated after the incident on 8/4/2022, when Resident #4 was wheeling Resident #2 outside, was when they put their foot down and the resident was transferred off the North Unit to the South Unit. The DON stated Resident #4 was still able to ambulate without a walker on South Unit. During an interview on 9/16/2022 at 1:30 PM, the Administrator stated they did not know about the 8/4/2022 incident with Resident #4 and Resident #3. The Administrator stated there were no grievance forms or I&A reports completed for the incident on 8/4/2022. The Administrator stated the incident on 8/4/2022 with Resident #4 would not have happened if the first incident on 7/26/2022 had been handled appropriately. The Administrator stated an I&A and investigation should have been completed for the alleged incident with Resident #3 on 8/4/2022 that was reported to the DRFS. The Administrator stated family choice and preference should not override the safety of the residents in the facility. The family of Resident #4 should have been called and told that Resident #4 was being moved for their safety and the safety of other residents. The resident should have been moved immediately and placed on a 1:1 for supervision after the 1st incident. The Administrator stated no new interventions were implemented after the incidents with Resident #4 on 7/26/2022 and 8/4/2022 and care plans were not initiated or updated for these residents. The whole process fell through from implementing safety interventions to investigating the incidents. During an interview on 9/16/2022 at 3:00 PM, the Attending Physician (AP) stated they were not aware of the incidents with Resident #s 4, 3, and 2. They had not been called about the incidents and would expect that another provider was called, t [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40348 Based on record review and interviews during an abbreviated survey (Case #NY00299618) the facility did not ensure an allegation of abuse was reported not later than 2 hours after the allegation was made to the New York State Department of Health (NYSDOH) for 1 (Resident #3) of 2 residents reviewed for abuse. Specifically, Resident #3 reported an allegation of sexual assault on 7/26/2022 at 4:45 AM to Registered Nurse (RN) #1 and was not reported to the NYSDOH until 29 hours later on 7/27/2022 by the Director of Nursing (DON). This is evidenced by: The policy and procedure (P&P) dated 5/2022 titled Resident Abuse Prevention and Reporting documented that upon suspicion of abuse of any kind, all employees are required to immediately notify the supervisor in charge of the building if during off-hours. Make immediate statement of observations or cause for suspicion and provide these to the supervisor. Failure to report abuse may result in disciplinary action. The purpose was to protect all residents and provide a safe environment and to comply with the Public Health Law for reporting abuse. The P&P did not include timeframes for reporting allegations of abuse to the State Agency or law enforcement. Resident #3: Resident #3 was admitted with post-traumatic stress disorder (PTSD), schizoaffective disorder, and respiratory failure with hypoxia. The Minimum Data Set (MDS- an assessment tool) dated 6/10/2022, documented the resident was cognitively intact, could understand others and could make themselves understood. Resident #4 was admitted with diagnoses of dementia, stroke, and Parkinson's disease. The Minimum Data Set (MDS- an assessment tool) dated 5/7/2022, documented the resident had severely impaired cognition, could usually understand others, and could usually make themselves understood. The Nursing Home Incident Intake Form dated 7/27/2022 at 9:38 AM, documented on 7/26/2022 at 4:45 AM, it was reported Resident #4 had gone into Resident #2 and Resident #3's rooms and touched them inappropriately. The investigation was on-going, and the facility's immediate response was to continue 15-minute checks with close supervision. The facility submitted the incident to the Department of Health on 7/27/2022 at 7:04 AM. Interviews: During an interview on 9/14/2022 at 11:35 AM, Registered Nurse (RN) #1 stated that they were supposed to report an allegation of sexual abuse right away to the NYSDOH and Administration but did not know the time frame. RN #1 stated that they made the Director of Nursing (DON) aware of Resident #3's allegation at 7:00 AM the morning of 7/27/2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/15/2022 at 3:25 PM, the DON stated that they became aware of the incident between Resident #4 and Resident #3 on 7/26/2022 at 7:00 AM and did not report the allegation to the NYSDOH until 7/27/2022 at 7:04 AM. During an interview on 9/16/2022 at 3:15 PM, the Administrator stated that to their knowledge the sexual abuse allegation made by Resident #3 was not reported to the NYSDOH or law enforcement. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. 40348 Based on record review and interviews during an abbreviated survey (Case #NY00299681) the facility failed to thoroughly investigate allegations of abuse for 2 (Resident #2 and #3) of 2 residents reviewed for abuse. Specifically, on 7/26/2022 at 1:30 AM, Certified Nursing Assistant (CNA) #3 observed Resident #4, who had severely impaired cognition, standing next to the bedside of Resident #2, who had moderately impaired cognition. Resident #2's sheets were off and hospital gown was pulled up. CNA #3 removed Resident #4 from the room. On the same day, 7/26/2022 at 4:45 AM, Resident #4 wandered into the room of Resident #3, who was cognitively intact and reported to CNA #3 and Registered Nurse (RN) #1 that they were sexually assaulted by Resident #4. Resident #3 stated they woke up to Resident #4 fondling their breast and inner thigh. Resident #3 has a history of Post-Traumatic Stress Disorder (PTSD) after being sexually assaulted as a child and reported experiencing increased anxiety as a result of this incident with Resident #4. The facility failed to complete a thorough investigation of the allegation of sexual abuse by Resident #4 that occurred on 7/26/2022. The facility did not report allegations of sexual abuse to law enforcement, and the facility did not submit an incident report to the department until 7/27/2022, 29 hours after the reported incident. As a result, the facility did not collect evidence to determine what occurred or what actions or systems were necessary to prevent sexual abuse by Resident #4 from reoccurring and failed to provide a safe environment to residents. This resulted in, or had the likelihood for, psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care to resident health and safety and had the likelihood to affect all residents in the facility. The Immediate Jeopardy was lifted on 9/16/2022. This is evidenced by: The Policy and Procedure (P&P) titled Resident Abuse Prevention and Reporting dated 5/2022, documented that upon receiving a report of suspicion of abuse of any kind, mistreatment, neglect or misappropriation of property, the supervisory/administrative staff were required to immediately initiate an investigation into the alleged incident. The investigation would proceed per the criteria on the investigative report, with documentation of all actions taken on an ongoing basis for the duration of the investigation. All abuse investigations would be reviewed by the Administrator, Medical Director, and Director of Nursing. Incident #1: The facility failed to complete a thorough investigation for Resident #2 after Resident #4 was removed from the bedside of Resident #2 where Resident #2 was observed by Certified Nursing Assistant (CNA) #3 in bed with their sheet down, and hospital gown up, exposing their incontinence brief and abdomen on 7/26/2022 at 1:30 AM. Resident #4: Resident #4 was admitted with diagnoses of dementia, stroke, and Parkinson's disease. The Minimum Data Set (MDS- an assessment tool) dated 5/7/2022, documented the resident had severely impaired cognition, could usually understand others, and could usually make themselves understood. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #2: Resident #2 was admitted with diagnoses of lung disease, bipolar disorder, and stroke. The Minimum Data Set (MDS- an assessment tool) dated 5/4/2022, documented the resident had moderately impaired cognition, could understand others, and could make themselves understood. The Incident and Accident (I&A) report dated 7/26/2022, initiated by RN #1, documented Resident #4 had inappropriate contact with another resident (Resident #2). The immediate action to protect resident safety was to maintain 15-minute checks for Resident #4. Situational factors included: there was only one aide and one nurse on the unit for the duration of 11 PM - 7 AM shift. The RN documented the resident was last seen at 4:30 AM and was wandering into other resident rooms. The medical record for Resident #2 did not include a Registered Nurse Assessment to assess for physical and psychosocial harm after the alleged incident with Resident #4 on 7/26/2022. The facility did not provide documentation that immediate measures were put in place to ensure that further potential abuse, neglect, exploitation, or mistreatment did not occur and did not provide documentation that a thorough investigation of the alleged violation was completed. During an interview on 9/15/2022 at 11:10 AM, Registered Nurse (RN) #1 stated they wrote up an I&A and got a statement from CNA #3 after the incident but did not start an investigation. During an interview on 9/15/2022 at 11:50 AM, the Assistant Director of Nursing (ADON) stated that they heard about the incident on 7/26/2022 between Resident #4 and #2 but they did not start an investigation. During an interview on 9/15/2022 at 3:25 PM, the Director of Nursing (DON) stated they were not aware of the incident with Resident #4 and Resident #2 until 7:00 AM, the morning of the incident and had not started an investigation on this incident. During a subsequent interview on 9/16/2022 at 3:07 PM, the DON stated the procedure for an investigation would be to get staff statements, care plans be established with new interventions and to see if the monitoring was effective. The DON stated that they should have gotten an interview with CNA #3 but did not. The DON stated they still had not done an investigation of the incident. During an interview on 9/16/2022 at 3:15 PM, the Administrator (ADM) stated that they were made aware of the incident on 7/26/2022 by a text message from the DON. The ADM stated they did not investigate the incident, and it was the responsibility of whoever was in charge at the time of an incident to start an investigation. The ADM stated that Resident #4 was on 15-minute checks and the ADM was told everything was done. That was the extent of their follow-up. Incident #2: For Resident #3, the facility failed to complete a thorough investigation for an allegation of sexual abuse by Resident #4 that was reported to CNA #3 and Registered Nurse (RN) #1 on 7/26/2022 at 4:45 AM. Resident #4 wandered into the room of Resident #3 who alleged to staff that they were sexually assaulted by Resident #4 when they woke to Resident #4 fondling their breast and inner thigh on 7/26/2022 at 4:45 AM. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #3: Resident #3 was admitted with post-traumatic stress disorder (PTSD), schizoaffective disorder, and respiratory failure with hypoxia. The Minimum Data Set (MDS- an assessment tool) dated 6/10/2022, documented the resident was cognitively intact, could understand others and could make themselves understood. The I&A report dated 7/29/2022, initiated by the Director of Nursing (DON) documented Resident #4 entered the room of Resident #3 without authorization. The A&I did not document the date and time of the incident. The medical record for Resident #3 did not include a Registered Nurse Assessment to assess for physical and psychosocial harm after the alleged incident with Resident #4 on 7/26/2022. The facility did not provide documentation that immediate measures were put in place to ensure that further potential abuse, neglect, exploitation, or mistreatment did not occur and did not provide documentation that a thorough investigation of the alleged violation was completed. During an interview on 9/14/2022 at 11:00 AM, Resident #3 stated they did not think the facility investigated the incident because they had not heard anything in response to the incident on 7/26/2022. During an interview on 9/14/2022 at 11:35 AM, Registered Nurse (RN) #1 stated they worked 7/26/2022 and they did not write an I&A report or start any investigation after Resident #3 alleged sexual abuse by Resident #4 because they had other priorities. During an interview on 9/15/2022 at 3:25 PM, the Director of Nursing (DON) stated they were aware of the incident with Resident #4 and Resident #3 on 7/26/2022 and had not started an investigation on this incident. During an interview on 9/16/2022 at 11:46 AM, the Nurse Practitioner (NP) stated they were aware of Resident #4's aggressive behaviors but unaware of their wandering. The NP stated these issues could have been addressed had they been investigated. The NP stated law enforcement was not called to their knowledge but should be with any allegation of sexual abuse. During an interview on 9/16/2022 at 1:00 PM, the Administrator (ADM) stated they had not started an investigation and had not called the police. Incident #3: The facility did not complete a thorough investigation when Resident #4 had unwanted contact with Resident #3 on 8/4/2022. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/15/2022 at 5:40 PM, Resident #3 stated on 8/4/2022 they were wheeling down the hallway in their wheelchair and Resident #4 had their arm extended with their hand on Resident #2's shoulder. Resident #3 stated that they could not get by and said excuse me and tried to go around both of them. Resident #4 put their hand on Resident #3's shoulder to prevent them from going around. Resident #3 stated they pulled away and then Resident #4 punched them in the left forearm leaving a bruise. The resident stated they reported this to a nurse who wrote said they would file a grievance on it. The facility did not provide an Investigation, Incident and Accident (I&A) report, or grievance form for the alleged physical incident on 8/4/2022 involving Resident #3 and Resident #4. Resident #3's medical record did not include documentation of the alleged unwanted physical contact with Resident #4 on 8/4/2022. Resident #3's medical record did not include a completed Skin Observation Tool or a Registered Nurse Assessment to assess for physical and psychosocial harm after the alleged incident with Resident #4 on 8/4/2022. During an interview on 9/14/2022 at 4:30 PM, the Director of Resident and Family Services (DRFS) on 8/4/2022, the family of Resident #3 called them and told them that there had been a repeat incident with Resident #4. The DRFS was not sure what a repeat incident meant but the DRFS was on their way to give Resident #3 a grievance form to report the repeat incident with Resident #4 when DRFS was distracted by Resident #2 who was screaming. The DRFS stated Resident #4 wheeled Resident #2 outside and Resident #2 did not want to go so they were screaming. The DRFS did not follow up with Resident #3 about the alleged unwanted contact on 8/4/2022, did not file a grievance for the resident, and did not notify Administration on 8/4/2022. During an interview on 9/15/2022 at 3:45 PM, the DON stated they were aware there was another incident on 8/4/2022 with Resident #3 and Resident #4 but was made aware after the fact. They did not complete an I&A report after finding out. The DON did not know about the alleged bruise. The DON just knew about an incident taking place and did not know the details and did not investigate. During an interview on 9/16/2022 at 1:30 PM, the Administrator stated they did not know about 8/4/2022 incident with Resident #4 and Resident #3. The Administrator stated there were no grievance forms or I&A reports completed for the incident on 8/4/2022. The Administrator stated the incident on 8/4/2022 with Resident #4 would not have happened if the first incident on 7/26/2022 had been handled appropriately. The Administrator stated an I&A and investigation should have been completed for the alleged incident with Resident #3 on 8/4/2022. The resident should have been moved immediately and placed on a 1:1 for supervision after the first incident. The Administrator stated no new interventions were implemented after the incidents with Resident #4 on 7/26/2022 and 8/4/2022 and care plans were not initiated or updated for these residents. The whole process fell through from implementing safety interventions to investigating the incidents. During an interview on 9/16/2022 at 3:00 PM, the Attending Physician (AP) stated they were not aware of the incidents with Resident #s 4, 3, and 2. The AP stated had they been called and informed of the incident, they could have given instructions or guidance on what to do for the resident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/19/2022 at 2:10 PM, the Medical Director stated they were not informed of the incidents on 7/26/2022 or 8/4/2022 with Resident #s 4, 3, and 2. The MD stated the resident should have had an RN assessment and if the staff had called them, they would have had the resident sent to the hospital for an evaluation. The MD stated that an investigation should have been done. The MD expected an investigation would have been done with details of what the problem was and how they fixed it. The Administrator was informed of the Immediate Jeopardy and provided the Immediate Jeopardy Template on 9/15/2022. On 9/16/2022, the facility submitted an allegation letter for the Removal of the Immediate Jeopardy. On 9/17/2022, an onsite survey was conducted, and the following corrections were taken by the facility: The facility implemented one to one supervision of Resident #4 that would be ongoing. The resident would be re-evaluated prior to removing the one-to-one supervision. The Policy and Procedure (P&P) titled Resident Abuse Prevention and Reporting dated 5/2022 was updated. Staff education as of 9/17/2022, was at a 92% completion rate with 97 of 102 employees and 6 of 8 agency staff were in-serviced by the DON and ADON. A packet on the new P&P was given and discussed with the employees before the start of their shift. Law enforcement was called, and a report will be filed regarding the sexual assault allegation. A thorough investigation for the incidents on 7/26/2022 and on 8/4/2022 will be substantially underway. All residents who wander and who were at risk for sexual misconduct or aggression or at risk for victimization due to cognitive status or past trauma were assessed. Specific education was rendered to the RN on duty at the time of events, identified deficient practice and appropriate actions that should have taken place. The RN was educated on abuse prevention, reporting, providing an immediate and appropriate intervention to keep residents safe. As a result of this survey, it was determined that the Immediate Jeopardy for F610 was abated as of 9/16/2022, prior to the exit date of 9/20/2022. 10 NYCRR 415.4(b)

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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. 40568 Based on record review and interview during an abbreviated survey (Case #'s NY00291872 and NY00298816), the facility did not ensure it developed and implemented an effective discharge planning process that focused on the resident's discharge goals for 2 (Resident #5 and #6) of 2 residents reviewed for discharge. Specifically, for Resident #5, the facility did not ensure the comprehensive care plan (CCP) included a discharge plan that was re-evaluated regularly and updated when the resident requested a lateral transfer to other facilities and when the resident's discharge goal changed from a lateral transfer to a discharge to the community with services; and for Resident #6, did ensure the CCP included a discharge plan that was re-evaluated regularly and updated when the resident was not discharged to an Assisted Living Facility as initially planned and subsequently, requested a lateral transfer. Additionally, for Resident #6, the facility did not ensure a timely discharge referral was made for a lateral transfer as requested by the resident and resident representative on 9/1/2022. This is evidenced by: The Policy & Procedure titled Discharge Plan Policy dated 7/2022, documented that before active program participation was concluded and prior to program approved discharge, staff would meet with each resident to develop and document an individualized strategy that would assist the participant in maintaining their recovery. The discharge planning process would be inclusive of the goals identified in the treatment plan it would include referrals to appropriate resources. Upon admission discharge goals would be established to expedite planning. Resident #5: Resident #5 was admitted with diagnoses of chronic pain syndrome, chronic obstructive pulmonary disease, and atrial fibrillation. The Minimum Data Set (MDS- an assessment tool) dated 8/7/2022, documented the resident was cognitively intact, could understand others and could make self understood. The Comprehensive Care Plan for discharge date d 6/7/2022, documented Resident #5 wished for a lateral transfer to (named facility #1). The intervention dated 6/7/2022, documented to encourage the resident to discuss feelings and concerns with impending discharge and to monitor for and address episodes of anxiety, fear, distress. The care plan was not re-evaluated regularly or updated when the resident's needs or goals changed. The CCP was not updated when the resident requested a lateral transfer to other facilities and when the resident's discharge goal changed from a lateral transfer to a discharge to the community with services Progress notes documented on: - 6/7/2022, (named facility #1) responded to the referral by informing the facility that they had an 8-10 week waiting list for long term care beds. - 7/15/2022, a phone call was received from family regarding a lateral transfer to (named facility #2). The requested paperwork was faxed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/9/2022, Resident #5 was scheduled for discharge on this date, 8/9/2022, but the writer was informed that the resident discharged with their family that morning without informing facility representatives of their departure. The resident was unable to receive their discharge summary and remaining medications. SW comfirmed with the resident's family that the resident arrived safely to their apartment and they had received a call regarding their oxygen delivery. The medical record did not include documentation that the discharge plan was re-evaluated or revised when the resident was interested in transferring to facility #2 or when the resident's discharge plan changed from a lateral transfer to a discharge to the community with services. Resident #6: Resident #6 was admitted with the diagnoses of heart disease, anxiety, and depression. The Minimum Data Set (MDS- an assessment tool) dated 3/4/2022, documented the resident was cognitively intact, could understand others and could make self understood. The Comprehensive Care Plan for Discharge, last revised 9/2/2022, documented the resident's lateral transfer to another nursing home. Interventions dated 6/15/2022 documented to encourage the resident to discuss feelings and concerns with impending discharge; to monitor for and address episodes of anxiety, fear, and distress; to establish a pre-discharge plan with the resident and their family; and to the evaluate the progress and revise the plan as needed. Progress notes documented on: -6/15/2022 at 10:38 AM, the resident was planning on transferring to (named) Assisted Living. The application was being completed by nursing staff and will be sent out as soon as possible. -6/23/2022 at 1:56 PM, the resident is pending a lateral transfer to an assisted living. -6/30/2022 at 11:14 AM, the resident will be transferred from this facility to a lower level of care in an assisted living setting. The resident was independent with the use of a rolling walker and wheelchair mobility. The medical record did not include documentation that the discharge plan to the assisted living facility was re-evaluated or revised. A progress note dated 9/1/2022 at 3:45 PM, documented a care conference meeting was held and the topic of discharge was brought up by family. It was explained to the resident that their positive changes were so recent that staff wanted to make sure that the resident's stability was maintained. The resident and family agreed to reassess in a month's time. It was also decided that the facility would make a referral to another nursing home in the meantime to be closer to family. As of 9/14/2022, the medical record did not include documentation that a discharge referral was made for a lateral transfer as requested by the resident and resident representative on 9/1/2022. Interviews: (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 9/14/2022 at 4:45 PM, the Director of Resident and Family Services (DRFS) stated for Resident #5, referrals were sent to 2 nursing homes for lateral transfers that the family had specifically requested. Resident #5's family went from requesting lateral transfers to requesting a discharge to home. For Resident #6, a referral was sent to an assisted living facility, but the referral had been rejected by the assisted living. Resident #6 and their family were looking to make a lateral transfer to a facility closer to the family. Resident #6 and their family had requested a later transfer referral be sent to a (named) facility during a care conference meeting on 9/1/2022, but the DRFS stated the referral had not been sent yet. The facility had not been contacted to initiate the lateral transfer as of 9/14/2022. The DRFS stated they had not been documenting with the frequency that they should have been, and this also included documentation of discharge care plans. The DRFS stated other residents in the facility also wanted lateral transfers and were waiting for referrals to be sent. During an interview on 9/19/2022 at 12:13 PM, the Administrator stated there should be a care plan in place for discharge planning and it should be started upon admission or within a reasonable amount of time after admission when it was decided what the discharge plan would be. The DRFS should be doing the care plans for discharge planning. The DRFS would initiate the discharge care plan and the Discharge Planning Nurse, Licensed Practical Nurse (LPN) #7, could add to care plan if there were any changes to the resident's discharge plan. The Administrator stated discharge planning was a problem and there was a back log of discharges that needed to be done. The Administrator stated they did not know the time frame in which a lateral transfer referral should be made after a resident and family requested it but stated it should not be long after the request was made. For lateral transfers, LPN #7 would call the other facility and would see if they had availability. Then they would send over the documents needed for the lateral transfer. During an interview on 9/19/2022 at 12:30 PM, LPN #7 stated upon admission they met with residents to see what their discharge goal was: long term care vs. short term placement. The LPN tried to start the discharge process upon admission. The LPN stated the DRFS completed the discharge care plans because the LPN could not initiate care plans. The LPN stated they had not added to or revised a discharge care plan since they had been in the role as the Discharge Planning Nurse. The LPN stated for lateral transfers, they would call the other facility and send them a referral within a day or 2 of the resident and family requesting the transfer. The LPN stated they were working with the DRFS on a back log of resident discharges that had piled up since this past February. 10NYCRR 415.11(d)(3)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40568 Based on record review and interview during an abbreviated survey (Case #NY00301729), the facility did not ensure that residents in need of respiratory care, received such care consistent with professional standards for 1 (Resident #1) of 1 resident reviewed for respiratory care. Specifically, for Resident #1, the facility did not ensure there was a physician order for oxygen (O2) use from [DATE]-[DATE] and did not ensure the resident's medical record included documentation of on-going monitoring of the resident's respiratory status from [DATE]-[DATE]. This is evidenced by: Resident #1: Resident #1 was admitted with diagnoses of urinary tract infection, diabetes, and chronic obstructive pulmonary disease. The resident was admitted for comfort care and expired on [DATE] at 7:11 PM. The Policy and Procedure (P&P) titled Oxygen Administration dated [DATE], documented that oxygen was to be administered by licensed nursing staff to patients requiring oxygen therapy in the presence of a physician order with a pertinent diagnosis. The need for oxygen in an emergency may be assessed and initiated by licensed nursing staff. Resident refusal for oxygen treatment must be documented in the treatment administration record (TAR) and the resident needed to be monitored for respiratory distress, shortness of breath, and oxygen saturation levels. The physician would be notified for changes in resident status. The Hospital Discharge Summary dated [DATE], documented oxygen via nasal cannula (NC) at a flow rate of 6 liters per minute (l/m) and to titrate O2 for comfort. The Baseline Care Plan initiated [DATE] did not include documentation of oxygen use. The Admission Physician Orders did not include an order for oxygen use. An admission nursing assessment dated [DATE], documented the resident was short of breath upon exertion and was on O2 at 6 l/m via NC. The medical record did not include documentation of subsequent nursing assessments. On [DATE] at 4:00 PM, the medical record documented an O2 saturation (percentage of oxygen in a person's blood) of 95%. The medical record did not include documentation of subsequent O2 saturations. A review of progress notes from [DATE] - [DATE] did not include documentation of the resident's respiratory status or oxygen use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:19 PM, Licensed Practical Nurse (LPN) #10 stated Resident #1 was on O2 at 6 l/m when they were admitted to the facility from the hospital. The resident received oxygen from an O2 tank in the facility in order to receive 6 l/m because the facility only had a concentrator that went up to 5 liters. The LPN stated they gave report to the oncoming nurse at change of shift on [DATE] but did not know what the oncoming nurse knew about the resident's O2 since there was no physician order for O2. The LPN stated nurses could use their nursing judgement to apply as needed (PRN) oxygen but usually a resident would have a physician order for oxygen use. During an interview on [DATE] at 4:10 PM, Certified Nursing Assistant (CNA) #8 stated Resident #1 was on an O2 concentrator set at 5 liters. Resident #1 was concerned about being on 5 liters and wanted to be on 2 liters. The CNA told the nurse, and the nurse agreed with the resident, that 5 liters was too much. The nurse lowered the oxygen to 2 liters. The CNA took the resident's O2 saturations at bedside but stated they did not document them in the medical record. The resident's O2 saturations had dropped to the 60s on 2 liters of O2 and the resident had difficulty breathing on 2 liters. The CNA stated the nurse used their nursing judgement to put the O2 back up to 5 liters and even on 5 liters, the resident was just 90%. During an interview on [DATE] at 10:53 AM, Registered Nurse (RN) #1 stated the resident received O2 via a concentrator. The RN stated staff were told the resident's representative bumped up the oxygen, so staff turned it back down. The RN stated they did not believe the resident had an order for O2 but nurses were able to place O2 on a resident for comfort. The RN stated they observed the resident, who appeared comfortable, but did not complete an RN assessment or monitor the resident's respiratory status. During an interview on [DATE] at 12:20 PM, the Assistant Director of Nursing (DON) stated they reviewed the resident's admission orders with the Nurse Practitioner (NP). The resident was on O2 in the hospital and when the resident came to the facility, the ADON put the resident on 2 liters. The NP gave an order for 2 liters of O2 for comfort. The ADON stated they changed the order to 6 liters based on the hospital paperwork and thought they put the oxygen order in the electronic medical record. The ADON stated there should have been an order for oxygen and the resident's use of oxygen should have been on the baseline care plan. During an interview on [DATE] at 11:39 AM, the Nurse Practitioner (NP) stated an oxygen order should have been there for Resident #1. If the resident was on 6 liters in the hospital, they would have been put on 6 liters in the facility. The NP stated the resident had a right to ask for the O2 to be lowered for comfort. The NP was not called overnight regarding the resident's respiratory status. During an interview on [DATE] at 4:42 PM, the Director of Nursing (DON) stated documentation in the medical records was poor and that was a problem. The DON stated oxygen should have a physician order, but nurses could place O2 on a resident for comfort. The nurse would call the physician if there were changes to the O2 or the resident's respiratory status. 10NYCRR 415.12(k)(6)

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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** 40568 Based on record review and interview during an abbreviated survey (Case #s NY00301729 and NY00298816), the facility did not ensure routine and emergency drugs and biologicals were obtained and provided to its residents and did not determine drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 2 (Resident #'s 1 and #5) of 2 residents reviewed for narcotic pain medication. Specifically, for Resident #1, the facility did not ensure the resident's narcotic pain medication, as ordered by the prescriber, was obtained and provided to the resident and did not ensure there was a system in place to ensure there were 2 nurses available in the facility to access the Automated Dispensing Device (Pixus). For Resident #5, the facility did not ensure there were no discrepancies between narcotic pain medication signed out on the Narcotic Count sheets and the electronic Medication Administration Record (eMAR). This is evidenced by: Resident #1: Resident #1 was admitted with diagnoses of urinary tract infection, diabetes, and chronic obstructive pulmonary disease. The resident was admitted for comfort care and expired on [DATE] at 7:11 PM. The Policy and Procedure (P&P) titled Medication Availability and Administration for Residents Upon Admission undated, documented the admitting nurse would obtain and review the discharge medication list from the hospital, or the admitting facility, with the medical provider prior to or upon admission to the facility either in person or by phone. Any changes made by the medical provider would be reflected in the transcribed orders and all medication orders would be entered into the medical record by a licensed nurse. The admitting nurse would call the pharmacy to ensure timely delivery of medications and the admitting nurse would report any issues with the medication orders to the medical provider and the Assistant Director of Nursing (ADON) / Director of Nursing (DON) immediately. The Policy and Procedure (P&P) titled Automated Dispensing Devices Medication Dispensing System undated, documented only licensed facility personnel, who have the approval of the Director of Nursing and appropriate training on the Automated Dispensing Device had access to medications in the Automated Dispensing Device. In the event of a system failure or malfunction, the facility would contact the Automated Dispensing Device customer support group for assistance, if the issue remained unresolved. The Hospital Discharge Summary dated [DATE], documented a medication order for Morphine Solution 10 MG (milligrams) = 5 ML (milliliters) oral solution every 4 hours as needed (q4h prn) pain or dyspnea for 7 days. Clinician Directions documented: May administer any ordered lower dose or less potent analgesic per patient request. A physician order dated [DATE], documented Morphine Sulfate tablet 15 MG; give 1 tablet by mouth 2 times a day for pain. Call the Nurse Practitioner (NP) if additional breakthrough doses were needed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The eMAR for Morphine Sulfate 15 MG documented on [DATE], see progress note and on [DATE], drug refused. Progress Notes dated [DATE] documented at: -6:58 PM, Morphine Sulfate tablet 15 MG; give 1 tablet by mouth 2 times a day for pain. Call NP if additional breakthrough doses were needed. The pharmacist was notified x3 of requiring access to Pixus for removal of medication. A voicemail was left with no return notification at this time. -10:41 PM, orders were verified with the NP. The facility's pharmacy was called and asked to STAT (urgent or rush) the medications. -11:28 PM, NP Admission Note: per hospital report relayed to the ADON, the resident had been refusing roxanol (Morphine) in the hospital and when offered Morphine Sulfate (MSO4) 15 MG, the resident accepted it. The nurse asked the resident if they would be agreeable to the pill and the resident was. The order was changed to accommodate the resident's preference. -11:42 PM, NP Note: the resident was admitted for comfort and end of life care. Medication and treatment orders reviewed and signed. During an interview on [DATE] at 12:19 PM, Licensed Practical Nurse (LPN) #10 stated the NP had given a one-time order for pain medication until the resident's medications arrived from pharmacy. The LPN went to the Pixus to obtain the medication but could not access the Pixus because the machine was asking for a 1-time validation code. The LPN called the pharmacy. The pharmacy said a validation code was not needed in New York State (NYS). The LPN stated the Pixus was messed up but had since been fixed. The LPN stated when Resident #1 first came from the hospital they were in discomfort. The LPN was trying to get the pain medication but could not access it from the Pixus. The NP also called the pharmacy to ask that the medication come STAT because it would not have come on the 6 PM pharmacy run since it took a few hours for the medication to come from the pharmacy in New Jersey. The pain medication had not come as of 11:00 PM when the LPN ended their shift and the LPN explained what was going on to the oncoming nurse and supervisor. During an interview on [DATE] at 3:40 AM, Customer Service Supervisor (CSS) #1 stated Resident #1's Morphine order date was [DATE] at 10:59 PM. The Morphine was delivered to the facility on [DATE] at 7:30 AM. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:53 AM, Registered Nurse (RN) #1 stated Resident #1 was admitted on the evening shift and in report they were told the evening supervisor was unable to access pain medication in the Pixus because it was asking for a code. The RN stated they called the pharmacy to get the code and the pharmacy declined that was an issue, stating NYS did not need a code. The RN used their fingerprint on the Pixus and saw on the screen of the Pixus that Morphine was listed. The Pixus would not let the RN access the medication because the RN needed a co-signature from another nurse to access it. The RN stated they asked staff in the building, but there was no one was in the building who could access the Pixus with the RN. The RN stated they were not going to pull Morphine at that point anyway because the resident was not exhibiting signs of pain even though there was a physician order for the medication to be provided. The RN stated the hospital notes made it seem like the resident did not want pain medication at all. The resident was given Tylenol. The RN stated the Pixus was an issue and their only recourse that night was to contact the pharmacy directly. The RN stated they did not need the medication, so they did not notify the physician. The RN did not notify Administration until the next day. The RN stated they realized there was a problem accessing narcotics during another instance days after they could not access the Pixus for Resident #1 when they had to contact staff at home to come into the facility to give the RN their fingerprint to co-sign for a narcotic medication. The RN stated more staff were now in-serviced on the Pixus, but agency staff did not have access to the Pixus, and it would be a problem if the RN was supervising with all agency nurses working. During an interview on [DATE] at 12:20 PM, the ADON stated they reviewed the admission orders with the NP and the orders in the computer for Resident #1. The ADON told the NP the hospital nurse reported the resident was refusing the pain medication because the resident did not like the way it made them feel. The NP ordered morphine in a tablet form. After they put the admission orders in the computer, the NP signed off on them, the ADON confirmed them and then the orders automatically go over to the pharmacy. There was glitch with the Pixus, and it would not dispense medication, but it had since been fixed. The ADON stated the RN should have called provider when they could not access the Pixus for Resident #1's Morphine because the RN did need access the Pixus to obtain the medication and could not. The ADON stated 2 nurses need to sign narcotics out of the Pixus and agency nurses did not have access. The ADON stated if that scenario happened, where there was one house nurse in the facility and a narcotic was needed from the Pixus, that would be a problem. The ADON stated the night supervisor should have called them and they would have come to the facility so the RN could access the Pixus for narcotic pain medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:39 AM, the NP stated they put Resident #1's admission orders in the computer with the admission nurse. The NP read the discharge summary that said the resident had repeatedly declined the Morphine. The resident agreed to take Morphine tablet 15 MG when they got to the facility and the NP ordered that. The resident declined the Morphine tablet when they arrived. It was the resident's right to decline. The NP stated they heard there was a problem with the Pixus the night the resident was admitted . The nurses and the NP called the pharmacy. The Pixus said something about a code being needed but pharmacy said the facility did not need a code. The Morphine order was signed and confirmed and in pharmacy's que, but the NP did not have the order cut off times from the pharmacy and did not know how late medications could be ordered. The last pharmacy run was at 9:00 PM and the resident's Morphine order was absolutely in before 9:00 PM. It should have come around 2:00 AM to the facility. It should have been on the midnight run, but if it came at 7:30 AM then it was on the Admission run. If the staff could not access the Pixus and needed a narcotic, they should call me and then the NP would call the pharmacy and request stat delivery. A stat delivery would be to the facility in 3 hours. The NP was not aware the staff could not access the Pixus throughout the night. They did not get a phone call back that there was still a problem with accessing the Pixus for Resident #1's medications. The NP stated it would be a massive problem if there was only 1 house staff and the rest agency staff who did not have access to the Pixus. During an interview on [DATE] at 4:42 PM, the DON stated the Pixus was originally set up wrong and required a code but was not fixed. The agency nurses did not have access to the Pixus. The DON did not know the Pixus was set up wrong until Resident #1's admission. The RN should have called the physician when they were unable to access the medication from the Pixus, but the resident did not need the medication. The DON stated the morphine was a physician order and if a nurse could not obtain the medication for whatever reason, they would call the physician to let them know. During an interview on [DATE] at 12:13 PM, the Administrator stated there was a problem with the Pixus, but the Administrator was not aware at the time. The Administrator stated they thought the Pixus was getting fixed, and it should be fixed now. The Administrator stated there was always at least one house staff working, with agency and would have to check about having 2 nurses in the facility who can access the Pixus for narcotics. During an interview on [DATE] at 12:30 PM, LPN #7 stated they were employed by the facility and did not have access to the Pixus and were not trained on it. They had not run into a problem because they have not been a medication cart very often recently, but it would be a problem if they were assigned to work on a medication cart and needed a narcotic from the Pixus. Resident #5: Resident #5 was admitted with diagnoses of chronic pain syndrome, chronic obstructive pulmonary disease, and atrial fibrillation. The Minimum Data Set (MDS-an assessment tool) dated [DATE] documented the resident was cognitively intact, could understand others and could make self understood. The Policy and Procedure (P&P) titled Narcotic Count Change of Shift dated ,d+[DATE], documented at the change of every shift the oncoming nurse would count controlled substances with the nurse going off shift and both would sign the change of shift narcotic count sheet. They controlled substances were counted at every shift change to maintain accountability and signatures of both nurses provided documentation. The P&P did not address ensuring narcotics were signed out on the change of shift narcotic count sheets and in the eMAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physicians Order dated [DATE], documented the resident was to receive hydrocodone-acetaminophen tablet 7XXX,d+[DATE] MG, give one tablet every 4 hours PRN for pain (scale of) ,d+[DATE]. The Control Record of Narcotics (narcotic sheet) from [DATE]-[DATE] for hydrocodone-acetaminophen 7XXX,d+[DATE] MG was signed out on: -[DATE] at 09:00 AM -[DATE] at 05:00 PM -[DATE] at 09:30 AM -[DATE] at 12:00 PM -[DATE] at 04:15 AM -[DATE] at 02:00 PM -[DATE] at 10:00 AM -[DATE] at 06:00 PM -[DATE] at 01:00 PM -[DATE] at 9:00 PM -[DATE] at 8:00 AM -[DATE] at 04:00 PM -[DATE] at 12:00 AM -[DATE] at 06:30 PM -[DATE] at 12:00 PM -[DATE] at 03:00 AM -[DATE] at 12:00 PM -[DATE] at 03:00 AM -[DATE] at 07:44 AM The eMAR did not include documentation from [DATE]-[DATE] on the above dates and times that hydrocodone-acetaminophen 7XXX,d+[DATE] MG was admininstered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:13 PM, the Administrator stated staff had to make sure the narcotic sheets and the eMAR matched when documenting. The DON and ADON were responsible for monitoring anything nursing. The Administrator would have to ask the DON what their process was for monitoring narcotic sheets and eMARs documented the same thing. During an interview on [DATE] at 12:30 PM, LPN #7 stated it happened all the time that the narcotic sheets and eMARs did not match. The nurse should be checking and signing the narcotic book and computer at the same time. The LPN stated some nurses only signed the narcotic sheet and some sign only the eMAR. The LPN stated it was a problem because a nurse could end up giving a dose of PRN narcotic medication too soon if the medication was not signed on the narcotic sheets and the eMAR. The nurse had to check both the book and eMAR before giving the narcotic. 10NYCRR415.18(a)