STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335797	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Osborn	101 Theall Road Rye, NY 10580

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification survey from 2/12/25 to 2/19/25, the facility did not ensure that the resident and/or resident representative were notified in writing of the reason for the transfer/discharge to the hospital for one of one residents reviewed for hospitalization (Resident #7). Specifically, Resident #7 was transferred to the hospital and the facility could not provide evidence that a written notice of transfer/discharge was provided to the resident or the resident's representative, and that notification was sent to the Ombudsman Office. Findings include: The facility policy and procedure titled Transfer and Discharge last revised 7/27/2022, documented before the facility will transfer or discharge a resident, the facility will provide a written notice to the resident and or representative in a manner and language in which the recipient can understand. The policy also required that a copy of the notice be sent to a representative of the State Long- Term Care Ombudsman's Office. The facility admission agreement documented the resident and their designated representative will be given prior written notice of the transfer or discharge in accordance with applicable regulations. Resident # 7 had diagnoses including schizophrenia, dementia, and chronic respiratory failure. The Quarterly Minimum Data Set, a resident assessment tool, dated 1/22/25 documented the resident had severe cognitive impairment. The progress note dated 8/22/24 at 5:23 PM documented Resident #7 experienced shortness of breath and wheezing. The physician was notified, and the resident was transferred to the hospital. The progress note dated 8/23/24 at 9:02 AM documented Resident #7 was admitted to the hospital with asthma exacerbation and respiratory distress. The progress note dated 8/29/24 at 11:30 AM documented Resident #7 returned to the facility in stable condition. Review of the resident's record on 2/18/25 revealed no documented evidence the family was notified or that Resident #7's representative received written information regarding transfer. A review of discharges and transfers submitted to the Ombudsman's Office for the month of August (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2024, revealed no documented evidence the Ombudsman was notified. During an interview on 2/18/25 at 1:00 PM, the Director of Social Services stated that social workers were responsible for providing the transfer/discharge notice and it was not completed for Resident #7. During an interview on 2/19/25 at 1:03 PM, the Director of Nursing stated the nursing staff and social workers collaborated to ensure that resident representatives were notified of the transfer to the hospital. The Director of Nursing was unable to explain why Resident #7's representative did not receive notification. During an interview on 2/19/25 at 1:10 PM, the facility Administrator stated the resident's family should have received written information regarding the transfer and discharge process. The Administrator further stated that the social worker and nursing staff were responsible for ensuring the notification was provided. During an interview on 2/19/25 at 4:00 PM, the Ombudsman office stated there was no documentation that the facility submitted information regarding Resident #7's discharge on [DATE]. 10 NYCRR 415.3(i)(1)(iii)(a-c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. Based on record review and interview conducted during the Recertification Survey conducted from 2/12/25 to 2/19/2,the facility did not ensure that a resident's representative was informed of the facility's bed hold policy before and upon transfer to a hospital for one of one residents reviewed for hospitalization (Resident #7). Specifically, Resident #7 was transferred to the hospital on 8/22/24, and the facility did not provide the resident or their representative written information regarding the bed hold. Findings include: The policy and procedure titled Bed Hold last revised 3/24/23, documented the resident and the representative would receive bed hold and return information at admission and before a hospital transfer. The policy further stated that a resident transferred to a hospital would receive written information regarding bed hold and payment amount. Resident # 7 had diagnoses including schizophrenia, dementia, and chronic respiratory failure. The Quarterly Minimum Data Set, a resident assessment tool dated 1/22/25 documented the resident had severe cognitive impairment. The progress note dated 8/22/24 at 5:23 PM, documented Resident #7 experienced shortness of breath and wheezing. The physician was notified, and the resident was transferred to the hospital. The progress note dated 8/23/24 at 9:02 AM, documented Resident #7 was admitted to the hospital with asthma exacerbation and respiratory distress. The progress note dated 8/29/24 at 11:30 AM, documented Resident #7 returned to the facility in stable condition. Review of the resident's medical record revealed no documented evidence Resident #7 or the representative received written information regarding the bed hold policy. During an interview on 2/18/25 at 1:00 PM, the Director of Social Services stated that social workers were responsible for providing bed hold policy notice and it was not completed. 10NYCRR 415.3 (i) 3(i)(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interviews during the Recertification survey from 02/12/2025 to 02/19/2025, the facility did not ensure that a complete preadmission screening was conducted. This was evident for 2 (Resident #169 and Resident # 35) residents reviewed for Preadmission Screening and Resident Review (PASARR) of 16 residents. Specifically, the SCREEN DOH - 695 form was incomplete. There was no documentation of answers to items 21, 24, 25, and 26. The findings are: The facility Policy with Title Preadmission Screening and Resident Review (PASARR) with effective date 01/15/2025 and last review date 01/1/2025 documented It is the policy to screen all potential admissions on an individual basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASARR) process (Level 1) for all new and readmissions per requirement to determine if the individual meets the criteria for mental disorder, intellectual disability, or related condition. Based upon the Level 1 screen, the facility will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen. 1) Resident #169 was admitted from acute care hospital with diagnoses and conditions including to spinal stenosis of lumbar region, Diabetes Mellitus, and Benign Prostatic Hypertrophy. The SCREEN Form DOH-695 completed for Resident #169 dated 7/25/2024, item # 21 was not answered. 2) Resident #35 was admitted from acute care hospital with diagnoses and conditions including fracture of the lower end of right radius, congestive heart failure, and atrial fibrillation. The SCREEN Form DOH-695 completed for Resident #35 dated 01/10/2025, the section Level I Review for Possible Mental Retardation/Developmental Disability (MR/DD) items 24, 25 and 26 were not completed. During an interview on 02/19/25 at 9:06 AM, the Director of Admissions stated they reviewed the screens for all residents prior to admission to the facility admission and ensured they were complete. During the interview, the Screen forms for Resident #169 and Resident #35 were reviewed with the Director of Admissions and they stated the items should have been answered. On 02/19/2025 at 10:43 AM, the Administrator stated the Admissions Department was responsible for reviewing the PASARR SCREEN forms prior to resident admission and they were unaware they were not complete. 10 NYCRR 415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification survey from 2/12/2025 to 2/19/2025, the facility did not ensure person-centered comprehensive care plans were developed with objectives and timeframe's to meet the resident's needs. This was evident for 1 (Resident #30) of 5 residents reviewed for unnecessary medications. Specifically, Resident #30 did not have a care plan developed to address antibiotic medication use. The findings are: Resident #30 had diagnoses of COVID-19, acute and chronic respiratory failure with hypercapnia, and urinary tract infection. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #30 had mild cognitive impairment, received anticoagulant medication, and received antibiotic medication. The Physician's Orders documented Resident #30 was ordered to receive Amoxicillin-pot clavulanate antibiotic 875-125mg twice daily prophylactically as of 1/27/2025 and Cefdinir antibiotic 300mg daily prophylactically as of 1/27/25. There was no documented evidence a Comprehensive Care Plan related to antibiotic use was developed and implemented for Resident #30. On 2/19/2025 at 10:49 AM, Registered Nurse #2 was interviewed and stated the admitting nurse was responsible for initiating care plans for newly admitted residents. Registered Nurse #2 stated they were the charge nurse for the unit and was responsible for reviewing all resident care plans within a few days of their admission to ensure the care plan reflected the resident's medical condition and medication regime. Resident #30 was prescribed antibiotics on a prophylactic basis upon their admission to the facility. Registered Nurse #2 stated they were unsure why the antibiotics were prescribed for Resident #30 and there should be a correlating care plan in place with interventions to monitor the resident for relative side effects. Registered Nurse #2 stated they had not reviewed Resident #30's chart since their admission to the facility and the antibiotic care plan had not been initiated and currently was not in place. 10 NYCRR 415.11(c)(1)

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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** Based on observation, interview and record review during the Recertification survey from 2/12/25 to 2/19/25, the facility did not ensure a resident who needed respiratory care was provided such care consistent with professional standards of practice for 1 of 2 residents (Resident #281) reviewed for respiratory care. Specifically, Resident #281 was receiving supplemental oxygen without a physician's order, indication for use, flow rate and route of administration. Findings include: Resident #218 had diagnoses including cerebral infarction, congestive heart failure, and asthma. The Minimum Data Set 3.0 (MDS) dated [DATE] documented Resident #218 was severely cognitively impaired and did not document the use of oxygen. The facility policy titled Oxygen Therapy and Evaluation effective 03/01/2024 and last reviewed 03/01/2024 documented A Physician/Nurse Practitioner/Physician Assistant order is required for oxygen therapy. The order must include the type of administration system to use, flow rate, and monitoring parameters. A Nurse Practitioner order dated 2/7/25 documented Titrate to maintain sat >92. There was no documented liter flow rate or route of administration. The February 2025 Treatment Administration Record documented to titrate to maintain sat greater than 92% every shift with a start date of 2/7/25 at 3:30 PM. The oxygen saturation was documented every shift however there was no documented Liter flow. The comprehensive care plan, revised 2/12/2025, documented no evidence the resident used oxygen. On 02/12/25 at 12:49 PM, Resident #218 was observed in bed with oxygen via nasal cannula. A bedside oxygen concentrator was delivering oxygen at 4 Liters per minute. On 02/13/25 at 09:25 AM, Resident #218 was observed in their room in in wheelchair, awake, alert, with oxygen via nasal cannula at 4 Liters per minute. During observation and interview on 2/14/25 at 10:45 AM, Licensed Practical Nurse #1 observed the bedside concentrator and stated the oxygen was set at 4 Liters per minute. They stated they documented the oxygen in the Treatment Administration Record. During an interview on 02/14/25 at 10:55 AM, Registered Nurse Manager #2 stated a physician's order was required for oxygen therapy and oxygen therapy was documented in the Medication Administration Record. Registered Nurse Manager #2, observed the resident's medical record and stated the Nurse Practitioner order dated 02/7/2025 was to Titrate to maintain saturation greater than 92%. Registered Nurse Manager #2 stated they did not see an order that mentioned oxygen. The February 2025 Treatment Administration Record documented Oxygen at 2 Liters via nasal cannula to maintain oxygen saturation greater than 92% with a start date of 2/14/25 at 3:30 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12 (k) (6)

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review conducted during the recertification survey from 2/12/2025 to 2/19/2025, the facility did not ensure the posted nurse staffing included the census and total actual hours worked by nursing staff. This was evident during review of Staffing. Specifically, the posted nurse daily staffing did not contain the facility's current census and actual hours worked by Certified Nursing Assistants on each shift. The findings are: The facility Daily Nurse Staffing dated 2/15/2025 documented 7 Certified Nursing Assistants worked on the 7:00 AM to 3:30 PM shift for a total of 52.5 hours. The Assignment Sheets for the 1st and 2nd Floors dated 2/15/2025 documented 8 Certified Nursing Assistants worked on the Day Shift. There is no documented evidence the 2/15/2025 Daily Nurse Staffing reflected the accurate number of actual working Certified Nursing Assistants on the 7:00 AM to 3:30 PM shift. The facility Daily Nurse Staffing dated 2/16/2025 documented 5 Certified Nursing Assistants worked on the 7:00 AM to 3:30 PM shift for a total of 37.5 hours and 7 Certified Nursing Assistants worked on the 11:30 PM to 7:30 AM shift for a total of 56 hours. The facility census was not documented. The Assignment Sheets for the 1st and 2nd Floors dated 2/16/2025 documented 1 of 5 Certified Nursing Assistants working on the Day Shift was late and 6 Certified Nursing Assistants worked on the Night Shift. There is no documented evidence the 2/16/2025 Daily Nurse Staffing reflected the accurate number of actual working Certified Nursing Assistants on the 11:30 PM to 7:30 AM shift and total hours worked by Certified Nursing Assistants on the Day Shift. The facility Daily Nurse Staffing dated 2/18/2025 documented 9 Certified Nursing Assistants worked on the 7:30 AM to 3:30 PM shift for a total of 67.5 hours. The Assignment Sheets for the 1st and 2nd Floors dated 2/18/2025 documented 10 Certified Nursing Assistants worked on the Day Shift. There is no documented evidence the 2/18/2025 Daily Nurse Staffing reflected the accurate number of actual working Certified Nursing Assistants on the 7:30 AM to 3:30 PM shift. On 2/18/2025 at 3:11 PM, the Daily Nurse Staffing was observed posted by the entrance to the facility on the 1st Floor resident unit. There was no documented evidence of the facility census. On 2/18/2025 at 3:18 PM, the Administrator was interviewed and stated the Staffing Coordinator was responsible for posting the Daily Nurse Staffing every day at the beginning of each day. The Administrator stated the Daily Nurse Staffing was not posted at the beginning of each shift, did not account for unforeseen changes to the schedule, and did not reflect the actual hours worked by nursing staff. The Daily Nurse Staffing did not include the facility's daily census, and the Administrator stated they were required to include census information in the daily posting. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.13

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based upon record review, observations,and interviews conducted during a recertification survey from 02/12/2025 to 02/19/2025, the facility did not ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Specifically, unmarked undated containers of food were observed in the refrigerator and freezer, and food was not maintained at the proper temperature in the second-floor dining facility's small refrigerator. The findings include: The facility policy Preparation of Potentially Hazardous Foods dated 03/01/2024, states that All potentially hazardous food is to be stored at or 45 degrees Fahrenheit or below and All potentially hazardous foods are to be visibly dated with the date of receipt unless previously dated with or by the manufacturer. Additionally, the facility policy cooling and storage states All storage areas will be inspected daily and weekly by supervisory staff to insure the correct labeling, dating, and storage standards are being met. An initial tour of the kitchen took place on 02/12/2025 at 9:38 AM with the Director of Food Services and the Executive Chef. During the tour of the produce refrigerator, multiple food items were observed unlabeled and undated. One tray containing two salmon fish, one plastic bag of herbs, and boxes of produce (zucchini, brussels, sprouts, and cantaloupe) were undated and unlabeled. During the tour of the freezer, five food items were observed unlabeled and undated while not in their original containers. One bag of pasta large shells, two bags of small pasta, and two bags of hash browns were observed unlabeled and undated. During an interview at the time of observation, the Executive Chef stated thet knew what the unlabeled food was and when it arrived since they did all the ordering. During an observation of the second-floor dining room on 02/13/2025 at 12:08 PM, the small refrigerator, which was stocked with food and snacks for the residents was recorded at an inside temperature of 46 degrees Fahrenheit. During the observation, the Dining Operations Manager stated that refrigerator temperatures were checked every day, and acknowledged the refrigerator was operating at a elevated temperture. 10 NYCRR 415.14 (h)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the recertification survey from 2/12/2025 to 2/19/2025, the facility did not ensure the facility-wide assessment was updated to determine what resources were necessary to care for residents competently during day-to-day operations. This was evident during review of Staffing. Specifically, the Facility Assessment did not include the education required by all personnel, a third-party staffing agency contract required to meet staffing needs, and used acuity data from 4/2023 through 6/2023 to determine their resident population staffing needs. The findings are: The Facility assessment dated [DATE] documented the facility had 42 resident beds on the Short Term Rehab Unit with 157 admissions and 42 resident beds on the Long Term Unit with 13 admissions between 4/2023 to 6/2023. The Facility Assessment documented the Resident Utilization Group percentages reflected on Minimum Data Set 3.0 assessments completed between 4/2023 and 6/2023. The Facility Assessment did not document the level of staff assistance required to assist residents with activities of daily living. The Staffing Plan did not document the required level of education for all personnel listed and did not include third-party staffing agency contracts used to meet staffing par levels. On 2/18/2025 at 3:18 PM, the Administrator was interviewed and stated they were responsible for creating the Facility Assessment and determining the staffing and equipment necessary to adequately serve residents. The Administrator stated the Facility Assessment staffing plan included nurse staffing par levels reflective of the facility's goals and not the actual numbers of staff required to provide day-to-day care to residents. The Administrator stated the facility identified the 1st Floor as the Short Term Rehab Unit and the 2nd Floor as the Long Term Unit a few years ago. The 2nd Floor was no longer defined as the Long Term Unit because the facility began using beds on this unit to accommodate an increasing number of short-term admissions. The Administrator stated the facility worked with a third-party staffing agency to meet their par levels and address staffing shortages in their schedule. The facility also used a computer application/program to create the nurse staffing schedule, communicate with staff regarding their schedule, and compile staffing data. 10 NYCRR 415.26