Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
What "No Harm" Really Means for Residents
New York State Special Issue

In This Issue:

Introduction: What is a "No Harm" Deficiency?

The New York State Department of Health (NYSDOH) works with the Centers for Medicare & Medicaid Services (CMS) to ensure that nursing homes in the state meet the minimum standards of care, as required by the federal Nursing Home Reform Law, its implementing regulations, and any state-specific requirements. As the case in all states, the effective monitoring and oversight of nursing home care by New York State (NYS) surveyors is a critical element to ensuring the safety and dignity of residents, as well as the integrity of the public programs which pay for the majority of nursing home care. Sadly, reports indicate that all too often state surveyors fail to identify when residents experience substandard care, abuse, or neglect. According to CMS data, even when NYS surveyors *do* identify health violations, they only identify a deficiency as having caused any harm to a resident about three percent (3%) of the time.

The failure to identify resident harm has pernicious implications at many levels. Fundamentally, it means that resident suffering and degradation–even death– go unaccounted for and are left unheard. Importantly, from a policy perspective, it means that there is likely no accountability, because nursing homes that violate a resident's right to quality care and quality of life services rarely face financial penalties for "no harm" deficiencies. In our view, this leads to systemic under-enforcement.

Share your thoughts with us on Twitter using **#HarmMatters**.

For more information on the nursing home standards of care, please see LTCCC's **Issue Alerts**.

The purpose of this newsletter is to provide the public with examples of "no harm" deficiencies in NYS, taken from Statements of Deficiencies (SoDs) on Nursing Home Compare (note that facility star ratings are current as of June 2019). Each of the nursing homes identified in this issue fall under the jurisdiction of one of the NYSDOH Regional Offices based on the county in which the facility is located. NYS surveyors classified all of these deficiencies as "no harm," meaning that they determined that residents were neither harmed nor put into immediate jeopardy for their health or well-being. We encourage our readers to read these residents' stories and determine for themselves whether or not they agree with the "no harm" determination.

Teresian House Nursing Home Co. (Albany County)

One-star facility failed to follow federal standards and its own policy, resulting in a resident being physically restrained.

The resident's record indicated that no restraints were being used.[1] However, the surveyor saw that the facility had been using a Lap Buddy, which is a cushion that rested on the resident's lap that fit "snuggly" within the frame of the wheelchair. The surveyor found that the Lap Buddy "could not be removed by the resident when requested by a Resident Care Coordinator (RCC) to do so."

A licensed practical nurse (LPN) explained that the resident was able to move the Lap Buddy but that it "takes her awhile and never on request." The nursing progress notes documented that the resident had an alarmed belt at one point but that it was ineffective in preventing her from standing up. As a result, the facility reinstated the use of the Lap Buddy and made changes to "prevent easy removal . . . ." The registered nurse unit manager (RNUM) told the surveyor that she did not consider the Lap Buddy to be a restraint. The facility's own restraint policy noted that a physical restraint is a "physical or mechanical device or equipment that is

attached or adjacent to a resident’s body that the individual cannot easily remove which restricts freedom of movement.”

The surveyor cited the facility for not “ensur[ing] residents were free of physical restraints. Although the facility failed to follow both the federal standards and its own policy, the surveyor still cited the facility’s violation as “no harm.”

Mountainside Residential Care (Delaware County)

Four-star facility failed to secure the resident in her wheelchair, resulting in a hematoma, lack of oxygen, bodily pain, and bruising.

The resident was sitting in her wheelchair in the facility’s transport van.[2] When the van accelerated to go up a hill, the resident fell backwards and hit her head, resulting in a hematoma to the right side of her head. The facility’s nurse progress notes documented that the resident had ice applied to her injury and was given oxygen because her lips and finger tips took on a bluish color, indicating a lack of oxygen. After the resident returned from the hospital, the progress notes documented that the resident complained of right shoulder, torso, arms, hip, back, neck, and head pain. The notes also documented “a purple bruise to her chest . . . and [a] dark purple/yellow area . . . from the resident’s ear to her neck.”

The facility’s investigation summary documented that the wheelchair restraint belts that were to be used during vehicle transportation were not properly used as directed by the manufacturer’s instructions. When the surveyor interviewed the certified nurse assistant (CNA) who drove the van, he told the surveyor the he used the two rear wheelchair belts but not the two front belts. The CNA added that he “had not received education on proper wheelchair securement for transportation . . . .” The director of nursing (DON) told the surveyor that there was “no documented evidence of wheelchair & occupant securement education for the transportation drivers.”

The surveyor cited the facility for “not ensur[ing] that the resident’s environment remained free from accident hazards. Specifically . . . the facility did not ensure that staff were trained on securing the four wheelchair restraint belts when transporting residents in the facility van.” Despite the resident’s injuries, the surveyor noted that the facility corrected the noncompliance before the survey and identified the deficiency as “no harm.”

The Commons on St. Anthony Street (Cayuga County)

Two-star facility failed to follow proper procedures when administering medications to a resident through his gastrostomy tube.

The resident had a gastrostomy tube inserted into his stomach for receiving “nutrition, fluids and medications as ordered.”[3] The resident’s care plan noted that staff should determine correct placement of the device before administering anything. The care plan called on staff to “follow standard of practice including listening with a stethoscope for an air bolus given through the [tube] . . . .” The physician ordered that the tube, if plugged, should be cleared with 120cc of water.

While observing the resident, the surveyor watched a licensed practical nurse (LPN) administer medication to the resident. The LPN did not determine whether the tube was correctly positioned before administering the medication and had difficulty because the “tube was clogged.” The LPN was also observed using a spoon handle that was “unclean and had been held by bare hands . . . [to stir] the medications which had settled in the medication cups.” When the surveyor later asked the LPN how she would verify the correct placement of the tube, the LPN said “I knew I missed something.”

On the following day, the surveyor observed as another LPN administered the resident’s medications, which were all crushed together. The surveyor noted that the LPN did not verify placement and did not have the “medication cart with [the] medication administration records to verify the medications . . . .” The LPN was also unable to flush the device and had to get help from a registered nurse (RN) to “unclog the tube.” The LPN later stated that she verified placement before the surveyor arrived. The RN told the surveyor that “medications could not be mixed together as it may cause a drug interaction.” The surveyor noted that the LPN “was an agency nurse and she received absolutely no training from the facility and all of her training had occurred while at school.”

The surveyor cited the facility for not verifying the placement of the resident’s gastrostomy tube before administering the medications and “not follow[ing] universal precautions and clean technique during the medication administration.” Despite these lapses in care, the surveyor cited the deficiency as “no harm.”

Fordham Nursing and Rehabilitation Center (Bronx County)

Two-star facility failed to care for the resident in a manner that enhanced his dignity, causing the resident to spend nearly two weeks without adequate clothing.

The resident was assessed as needing assistance with dressing and that it was important to the resident to be able to choose what clothing to wear.[4] When the resident was observed wearing a hospital gown, he told the surveyor that he has no clothes and has been asking for clothes since being admitted to the facility.

During a subsequent interview several days later, the resident was observed wearing a hospital gown and black pants. The resident told the surveyor that he had a doctor’s appointment and the nurse gave him pants to wear because “it was cold outside.” The resident told the surveyor that he borrowed a jacket from another resident. The resident explained that he has been eating his lunch in his room because he did not want to eat lunch with the jacket on and he was “not allowed to eat in the dining room [while] wearing a hospital gown.” The resident added that he requested to speak to the social worker to help get clothes. According to a CNA, the resident had been referred to the social worker but the social worker had not yet met with the resident.

The licensed practical nurse (LPN) told the surveyor that CNAs must inform the nurse when a resident needs clothes so that the nurse can request donated clothes and a social worker referral. The LPN also stated that CNAs must document that a resident has no clothes on the inventory sheet, which was not done in this case. The LPN admitted that she “did not know why the resident went 13 days without clothes.”

The surveyor cited the facility for failing to “ensure that residents were cared for in a manner that enhanced their dignity.” Although the federal Nursing Home Reform Law requires each facility to “provide services to

attain or maintain the highest practicable physical, *mental*, and *psychosocial well-being* of each resident,”[5] the facility’s violation was identified as “no harm.”

Promenade Rehab and Health Care Center (Queens County)

Three-star facility failed to follow proper infection control policies and procedures, exposing a resident to potential wound infection.

The resident assessment noted that the resident “was at risk for developing pressure ulcers, and currently had pressure ulcers.”[6] The resident’s comprehensive care plan provided that staff must maintain infection control policies and procedures when providing wound care to the resident.

During a resident observation, the surveyor watched as a registered nurse (RN) and a licensed practical nurse (LPN) provided wound care to the resident. The RN and LPN were observed touching the resident, sheets, and bed without wearing gowns. When the surveyor asked the RN and LPN whether they should be wearing gowns, given that the resident was on “contact precautions,” the RN instructed the LPN to get gowns from the isolation cart.

After the RN cleaned the resident’s wound, the LPN allowed the resident’s wound to come into contact with the bed sheets. As a result, the resident’s wound had to be cleaned again. The RN then applied the required medication and protective dressing before moving on to the resident’s other wound. However, the surveyor observed that the RN did not perform proper hand hygiene between cleaning the wound, applying the medication, and moving on to the next wound. When the surveyor brought this error to the RN’s attention, she acknowledged that she “should have performed hand hygiene after cleansing the sacrum [(the first wound)] . . . .”

The surveyor cited the facility for failing to “ensure that staff practices were consistent with current infection control principles and those practices prevent cross contamination.” Despite potentially exposing the resident to infections, the surveyor cited the facility’s deficiency as “no harm.”

Staten Island Care Center (Richmond County)

Two-star facility gave a resident an antipsychotic drug without psychiatric follow-up and behavioral evidence to support continued use.

The resident assessment showed that the resident’s cognition was intact, she had no behavioral issues, and had received an antipsychotic drug.[7] The resident’s comprehensive care plan for “Psychoactive Medication Use” ordered staff to administer her the drug and to do a psychiatric follow-up. The care plan did not have any documented non-pharmacological interventions and did not address behavioral concerns.

The psychiatric evaluation noted that the resident was “neat, clean . . . [a]wake, alert . . . .” There was no documentation regarding when the antipsychotic was to be tapered or discontinued, nor any indication as to when the next evaluation should be. The surveyor also found that there was no documentation of a follow-up psych evaluation or attempts at a gradual dose reduction since the resident’s admission to the facility, as well as “no documentation of behaviors or other justification for the continued use of antipsychotic medication.”

When the surveyor interviewed the physician, she told the surveyor that “the resident was so stable on the medication . . . [that] she did not think adjustments needed to be made so [the] psychiatric follow-up may have been overlooked.” The physician also admitted that the she was “aware of the initiative to reduce use of . . . [antipsychotic] medications in nursing homes and does review the resident’s medication on a monthly basis when doing notes but for some reason still missed it for this resident.”

The surveyor ultimately cited the facility for failing to “ensure that the resident’s drug regimen was free of unnecessary medications, finding that the resident was prescribed the antipsychotic medication “without psychiatric follow-up and with no evidence of behaviors to support ongoing use . . . .” Despite the resident being on an antipsychotic drug without support for its use, the facility’s violation was cited as “no harm.”

The Riverside (New York County)

Three-star facility failed to develop a care plan for addressing the resident’s loss of teeth. The assistant director of nursing noted that a review of care plans “must have been missed.”

When the surveyor greeted the resident, the resident smiled and “broken teeth were observed in the upper jaw with missing teeth on both sides of the lower jaw.”[8] The resident told the surveyor that she had lost some teeth since being admitted to facility. Dental orders and progress notes documented “multiple roots and missing teeth on the upper jaw and two root fragments and missing teeth on both sides of the lower jaw.” The annual oral exam indicated, in part, that the resident had remaining teeth, soft-tissue within normal limits, and no dentures. However, the resident’s care plan provided no evidence that “a Comprehensive Care Plan had been developed to address the resident’s oral/dental concerns.”

During an interview with the licensed practical nurse (LPN), the LPN told the surveyor that a registered nurse or manager was responsible for starting the care plan process. The assistant director of nursing, a registered nurse, told the surveyor that the resident was transferred from another unit and “review of . . . the care plans must have been missed.” The facility’s own policy for comprehensive care plans noted that the facility must develop a plan for each resident that “includes measurable objectives and timetables to meet a resident’s medical, nursing, mental, and psychosocial needs . . . .”

The surveyor cited the facility for failing to “ensure that a resident Comprehensive Care Plan (CCP) was developed that included measureable objectives and timeframes to meet each resident’s medical needs.” Although the facility failed to meet the required standards of care and its own policy, which resulted in the resident’s unmet dental care needs, the surveyor cited violation as “no harm.”

Downtown Brooklyn Nursing and Rehabilitation Center (Kings County)

Five-star facility failed to adequately meet multiple standards of care, contributing to a resident’s death.

The resident called a certified nursing assistant (CNA) to her room because she was not feeling well and had vomited.[9] After checking on the resident, the CNA told a licensed practical nurse (LPN) about the resident’s status and the LPN went to the resident’s room to check on her. The LPN told surveyors that she checked the

resident’s vital signs and gave her a ginger ale for the nausea. The LPN added that she spoke to the resident for about twenty minutes before leaving the resident’s room to inform the registered nurse (RN). According to the LPN, the RN’s response to the LPN was “ok.” The LPN stated that the resident’s daughter came out of the resident’s room to get the RN “about 15 minutes or more” after the LPN left the resident’s room.

The RN told the surveyor that she was in the dining room by the time the resident’s daughter came up to her and “grabbed her by the hand stating, [c]ome with me.” The RN followed the resident’s daughter to her room, where they found the resident “lying in bed unresponsive.” Although the LPN attempted CPR, the resident was pronounced dead soon after. The director of nursing service (DNS) later told the surveyor the she “was not aware that the RN did not assess the [r]esident . . . and that the doctor was not informed . . . .”

Based on these and other facts, the surveyor cited the facility for failing to “ensure that a physician was immediately notified of a change in a resident medical condition;” “ensure professional standards of quality were met;” “ensure that a resident received the necessary care and services required to maintain the highest practicable well-being;” and “develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs.” Nevertheless, despite the resident’s death, these citations were cited at the “no harm” level.

The Hamptons Center for Rehabilitation and Nursing (Suffolk County)

Four-star facility failed to give resident the correct antiarrhythmic medication for ten days. Five different nurses were responsible.

While the surveyor was observing the resident, a licensed practical nurse (LPN) attempted to administer an antiarrhythmic medication to the resident.[10] The LPN took a blister pack with a 400 milligram (mg) dose and put it into a medication cup. The surveyor had to stop the LPN because, as ordered by the physician, the resident was supposed to receive a lower dose. The LPN threw out the 400mg dose and administered the 200mg dose to the resident instead. The LPN told the surveyor that the 400mg dose was discontinued and should not have been on the medication cart.

When the surveyor reviewed the medication administration record, the documents indicated that the resident had received ten tablets at the wrong dose. The surveyor noted that the 400mg packet was observed in the “top drawer of the cart with other medications that are given to the resident . . . [while] the 200mg was observed in the bottom drawer of the cart unused . . . .”

The assistant director of nursing services (ADNS) acknowledged that “there were 10 doses that were given in error . . . [and] five nurses were responsible for giving the wrong doses . . . .” The physician told the surveyor that the medication needed to titrated (process of determining correct dose), otherwise “arrhythmias . . . can occur.”

The surveyor cited the facility because the resident “received 10 days of the wrong dose . . . by five Licensed Practical Nurses.” Although the resident was given the wrong dose for over a week, which could have caused medical complications, the violation was cited as “no harm.”

Glengariff Health Care Center (Nassau County)

Three-star facility failed to assess resident’s decline in health, as resident went from “frequently” to “always” incontinent of urine.

Upon admission to the facility, the resident assessment showed that the resident was “frequently incontinent of urine.”[11] A subsequent assessment indicated that the resident’s health declined, as the resident was documented as “always [being] incontinent of bladder.” The resident’s comprehensive care plan noted the problem and placed the resident on a toileting schedule of every two hours.

When the surveyor reviewed the resident’s medical record, the surveyor found no documented evidence that the resident’s decline from “frequently” to “always” incontinent of urine was properly assessed in order to determine the cause of the decline. Furthermore, the surveyor found that “no new interventions were implemented to achieve or maintain as much normal urinary function as possible.”

During staff interviews, the director of nursing services (DNS) acknowledged that the nurse who did the assessment should have “ensured an assessment was completed . . . to determine the cause of the decline.” The surveyor ultimately cited the facility for failing to “ensure that a resident who had a decline in urinary incontinence was assessed for interventions or to determine the cause of the decline in bladder function.” Although the resident’s decline in health was not properly addressed, the facility’s deficiency was only cited as “no harm.”

Humboldt House Rehabilitation and Nursing Center (Buffalo Office)

One-star facility failed to maintain a resident’s nutritional status within “acceptable parameters,” leading to significant weight loss.

The resident assessment documented that the resident’s normal body weight fluctuated between 165 to 170 pounds.[12] The assessment also noted that the resident’s nutritional needs were based on the resident’s weight at the time the resident was discharged from the hospital. Sadly, a subsequent assessment “reflected a significant weight decline to 156.6 [pounds].”

An inspection of the quarterly nutritional progress notes indicated that the facility took no measures to change the resident’s meal plan, in order to address the weight decline, for nearly two months. At that time, the resident’s spouse “voiced concerns that the resident was not getting enough food at meals.” The dietary progress notes recommended that the resident’s meal plan be altered to include “double entrée portions and mashed potatoes with gravy three times a week.” Another assessment later showed that the resident’s weight declined to 152.3 pounds.

The surveyor found that there was a “lack of documentation of meal consumption for 24 of 75 meals.” A registered nurse (RN) clarified for the surveyor that “nurses are responsible to assure the meal consumption sheets are completed . . . [and that] [i]t’s been a problem, we are working on it.”

The surveyor ultimately cited the facility for failing to “ensure that resident maintains acceptable parameters of nutritional status, such as body weight and protein levels . . . .” The surveyor added that one resident

"reviewed for nutrition had issues including the lack of timely nutritional intervention to address significant weight loss and a lack of complete documentation of the resident's actual meal consumption." Despite these findings, the surveyor cited the facility's deficiency as "no harm."

Latta Road Nursing Home West (Monroe County)

Four-star facility gave a resident an antipsychotic drug after attempts to leave the facility. Surveyor noted lack of proper documentation and non-pharmacological interventions.

The resident's comprehensive care plan for elopement indicated that the resident posed high risk of elopement and noted approaches for dealing with this issue as "redirect as needed, engage in activity, attempt to determine cause of trying to leave . . . offer to assist the resident back into the building . . . if [the] weather is nice offer to go for a walk."[13] A subsequent physician order, however, allowed for the use of an antipsychotic drug to treat an acute medical condition and agitation, which was to be given for "elopement attempts x 2."

The nursing progress report documented the resident leaving the facility, causing the door alarm to go off. The record showed that the resident was "promptly returned and his family was notified." A second nursing note documented that the resident again left the facility before being guided back by staff. After the second elopement, the nurse practitioner (NP) ordered the antipsychotic drug to be administered. When the surveyor interviewed the licensed practical nurse (LPN) manager, the LPN manager stated that the NP should have documented the resident's behavior. The NP told the surveyor that the event should have been documented in the progress notes.

The surveyor ultimately cited the facility for not "ensur[ing] that each resident's drug regimen remained free from unnecessary medications." The surveyor added that the "issue involved the lack of documentation of the resident's behavior, [and] non-pharmacological interventions attempted prior to the administration of a one time dose of an antipsychotic medication . . . ." Although the resident inappropriately received an antipsychotic drug, the facility's violation was cited as "no harm."

Further Reading from LTCCC & the Center:

1. LTCCC's Selected Enforcement Actions Taken By The NYS Attorney General Medicaid Fraud Control Unit 2018 (excel)
2. LTCCC's Selected Actions of the NYS Office of Medicaid Inspector General 2018 (excel)
3. LTCCC Memo: Addressing the Growing Problem of Inappropriate and Harmful Nursing Home Discharges in New York
4. Buying and Selling Nursing Homes: Who's Looking Out for the Residents?
5. CMS Tries Again: Another New Skilled Nursing Facility Medicare Reimbursement System Proposed – If Implemented, Would Gut Therapy

Elder Justice: What "No Harm" Really Means for Residents is a monthly newsletter published by the Center for Medicare Advocacy and the Long Term Care Community Coalition. The purpose of the newsletter is to provide residents, families, friends, and advocates information on what exactly a "no harm" deficiency is and what "no harm" actually means to residents.

[1] Statement of Deficiencies for Teresian House Nursing Home Co., CMS (Sept. 21, 2016), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335627&SURVEYDATE=09/21/2016&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=TERESIAN%2520HOUSE%2520NURSING%2520HOME%2520CO&Distn=0.0.

[2] Statement of Deficiencies for Mountainside Residential Care, CMS (Feb. 8, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335339&SURVEYDATE=02/08/2018&INSPTYPE=CMPL&profTab=1&state=NY&lat=0&lng=0&name=MOUNTAINSIDE%2520RESIDENTIAL%2520CARE&Distn=0.0.

[3] Statement of Deficiencies for The Commons on St. Anthony Street, A Loretto SNF, CMS (Sept. 8, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335382&SURVEYDATE=09/08/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=THE%2520COMMONS%2520ON%2520ST%2520ANTHONY%2520STREET%252C%2520A%2520LORETTO%2520S%2520N%2520F&Distn=0.0.

[4] Statement of Deficiencies for Fordham Nursing and Rehabilitation Center, CMS (Feb. 2, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335659&SURVEYDATE=02/02/2018&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=FORDHAM%2520NURSING%2520AND%2520REHABILITATION%2520CENTER&Distn=0.0.

[5] 42 U.S.C. § 1395i–3(B)(2) (emphasis added).

[6] Statement of Deficiencies for Promenade Rehab and Health Care Center, CMS (April 24, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335292&SURVEYDATE=04/24/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=PROMENADE%2520REHAB%2520AND%2520HEALTH%2520CARE%2520CENTER&Distn=0.0.

[7] Statement of Deficiencies for Staten Island Care Center, CMS (Dec. 23, 2016), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335561&SURVEYDATE=12/23/2016&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=STATEN%2520ISLAND%2520CARE%2520CENTER&Distn=0.0.

[8] Statement of Deficiencies for The Riverside, CMS (June 28, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335334&SURVEYDATE=06/28/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=THE%2520RIVERSIDE&Distn=0.0.

[9] Statement of Deficiencies for Center for Nursing and Rehabilitation SNF, CMS (Jun. 13, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335625&SURVEYDATE=06/13/2017&INSPTYPE=CMPL&profTab=1&state=NY&lat=0&lng=0&name=CENTER%2520FOR%2520NURSING%2520AND%2520REHABILITATION%2520S%2520N%2520F&Distn=0.0.

[10] Statement of Deficiencies for The Hamptons Center for Rehabilitation and Nursing, CMS (June 2, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335850&SURVEYDATE=06/02/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=THE%2520HAMPTONS%2520CENTER%2520FOR%2520REHABILITATION%2520AND%2520NURSING&Distn=0.0.

[11] Statement of Deficiencies for Glengariff Health Care Center, CMS (Apr. 24, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335211&SURVEYDATE=04/24/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=GLENGARIFF%2520HEALTH%2520CARE%2520CENTER&Distn=0.0.

[12] Statement of Deficiencies for Humboldt House Rehabilitation and Nursing Center, CMS (June 21, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335164&SURVEYDATE=06/21/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=HUMBOLDT%2520HOUSE%2520REHABILITATION%2520AND%2520NURSING%2520CENTER&Distn=0.0.

[13] Statement of Deficiencies for Latta Road Nursing Home West, CMS (Mar. 9, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335617&SURVEYDATE=03/09/2018&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=LATTA%2520ROAD%2520NURSING%2520HOME%2520WEST&Distn=0.0.