

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>44838</p> <p>Based on observation, interview, and record review during the recertification survey conducted 8/1/2024-8/7/2024, the facility did not ensure the right to reside and receive services with reasonable accommodation of resident needs and preferences for 10 of 10 residents (Residents #2, #18, #53, #58, #59, #66, #67, #101, and #312) reviewed. Specifically, Residents #2, #18, #53, #58, #59, #66, #67, #101, and #312 were previously assessed for appropriate siderail use to improve functional independence and bed mobility, and their siderails were subsequently removed without explanation or replacement of an alternative positioning device.</p> <p>Findings included:</p> <p>The facility policy, Use of Side Rails, originally dated 4/10/2028 and reviewed 7/29/2024 documented the facility was siderail free. All admissions into the facility would be evaluated by the rehabilitation therapy department to assess their ability for mobility and transfer. Upon the results of the therapy evaluation, alternative methods of mobility and transfer would be put into place should the assessment determine the resident needed additional assistance. Should the Interdisciplinary Care Team deem that a siderail was the only alternative and was medically necessary for a resident, the final determination would be made by the Director of Nursing based on documentation and evaluations from the entire Interdisciplinary Care Team.</p> <p>1) Resident # 53 had diagnoses of cardiomyopathy (a disease that affects the heart muscle), chronic obstructive pulmonary disease (lung disease), and diabetes. The 7/16/2024 Minimum Data Set admission assessment documented the resident had intact cognition, did not have behavioral symptoms, required substantial assistance for bed mobility and transfers, was at risk for developing pressure ulcers, and did not use side rails.</p> <p>The 7/9/2024 admission face sheet documented the resident was their own responsible party.</p> <p>The 7/9/2024 Bed Rail assessment completed by nursing and therapy documented for bed mobility and transfers the resident had bed rails that were used for positioning from side to side, pulling and holding self over, aiding in supporting self, and aiding in safe entry into bed. Therapy assessed the resident would use the bed rails for turning side to side, moving up and down in bed, holding self to one side, pulling self from lying to sitting position, for improving balance during transfers, supporting self during transfers, exiting bed safely, and entering bed safely. Bilateral quarter bed rails were recommended to enable the resident to achieve their highest level of functional.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>independence in bed mobility and transfers.</p> <p>A 7/26/2024 at 3:03 PM Director of Nursing progress note documented the Interdisciplinary Team and provider determined the use of bed rails was not medically required and the resident's bed rails would be removed. The resident's wife was spoken to and agreed with the plan.</p> <p>An 8/1/2024 physician order documented bilateral enablers/ 1/4 bed rails to bed were discontinued.</p> <p>During an interview on 8/2/2024 at 11:06 AM, Resident# 53 stated their bed rails were removed from their bed with no explanation and they had used them for independent bed mobility. Their bed was very narrow and without the bed rails it was difficult to move around in bed. Maintenance came in and removed them with no explanation. They were not offered an alternative assistive device to aid in bed mobility. They stated it would have been all right for the change to be discussed with their spouse, but they felt they should have been notified also.</p> <p>2) Resident # 67 had diagnoses of rheumatoid arthritis (a chronic inflammatory disorder that can affect joints), diabetes, and depression. The 7/2/2024 quarterly Minimum Data Set assessment documented the resident had intact cognition, required partial assistance with bed mobility and transfers, was at risk for pressure ulcers, and did not use bed rails.</p> <p>The 7/2/2024 bed rail assessment completed by nursing and therapy documented the resident used bed rails for turning from side to side, moving self up and down in bed, pulling and holding self over, pulling self from lying to sitting position, aiding in safe entry into bed, and aiding in safe exiting from bed. Therapy assessed the resident would use the bed rails for bed mobility and transfers. Bilateral quarter bed rails were recommended to enable the resident to achieve their highest level of functional</p> <p>independence in bed mobility and transfers.</p> <p>An 8/1/2024 physician documented bilateral enablers/ 1/4 bed rails to bed were discontinued.</p> <p>During an interview on 8/6/2024 at 9:44 AM Resident # 67 stated they were never told their bed rails were going to be removed. The bed rails were removed about 2 weeks ago while they were out of the room. The 2 rails were always up, and they needed stand by assistance of one person with the rail. They stated without the rails, they were shaky because they were afraid of falling. Now if they wanted to reposition themselves in bed it was not as easy because they had nothing firm to hold on to. Their bed mobility/side rail use was not reevaluated, and they were not offered any alternative assistive device. They stated they mentioned their concern to staff. Staff told them they heard the same complaint from everybody and that it was a State law they could not change.</p> <p>During an interview on 8/6/2024 at 12:07 PM, Certified Nurse Aide #29 stated residents had the bed rails taken away because of the State. There were complaints from residents almost every day, especially when they rolled residents in bed. Bed rails were used for rolling, helped with standing, and helped promote independence. Resident #67 had bed rails they used to pull themselves side to side and in and out of bed. Staff now had to bear more of their weight with transfers, whereas before they did not. The resident was shakier and was fearful without the bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) Resident #2 had diagnoses including surgical aftercare following surgery of the digestive system, paraplegia (paralysis of the legs), and pressure ulcers sacral region. The 6/26/2024 Minimum Data Set comprehensive assessment documented the resident had intact cognition, required assistance with bed mobility and transfers, was at risk for pressure ulcers, and did not use bed rails.</p> <p>The 6/19/2024 admission face sheet documented the resident was their own responsible party.</p> <p>The 6/20/2024 bed rail assessment completed by nursing and therapy documented the resident had bed rails used for turning from side to side, moving self up and down in bed, and pulling and holding self over. Therapy assessed how the resident would use the bed rails and recommended bilateral quarter bed rails to enable the resident to achieve their highest level of functional independence in bed mobility and transfers.</p> <p>A 7/25/2024 at 3:34 PM Director of Nursing progress note documented they met with the resident regarding removal of bed rails. The resident was assured that therapy and nursing would assess the resident to meet their comfort and safety needs. Risks versus benefits of bed rails were discussed with the resident and the resident voiced understanding. There was no documented reason for the removal of the resident's bed rails.</p> <p>During the resident council meeting on 8/1/2024 at 2:10 PM, Resident #2 stated they attended the meeting specifically to bring up their bed rails being removed. They stated they were reluctant to bring it up as it could cause unrest. Several residents stated their bed rails were removed without it being discussed with them. They stated they were told by the facility it was a state law they could not have bed rails.</p> <p>An 8/2/2024 physician order documented discontinue bilateral enablers/ 1/4 bed rails to bed.</p> <p>During an interview on 8/5/2024 at 2:41 PM, Resident # 2 stated maintenance just came and took the bed rails off. Maintenance said they were told to take them off. The resident stated no one talked to them about removing the bed rails before then. They were not given a choice or offered an alternative. They stated they had a trapeze since after admission and had requested it to pull up on and try to their strengthen arms. They were not able to use it to reposition themselves in bed.</p> <p>During an interview on 8/6/2024 at 10:12 AM, Certified Nurse Aide #28 stated nobody had bed rails anymore. They were all removed because of State law. Resident #2 had bed rails previously, and they were probably the most upset about the removal. They now needed assistance to roll in bed. The trapeze only helped them to sit up, it did not help them roll independently.</p> <p>During an interview on 8/6/2024 at 10:17 AM, Registered Nurse Unit Manager #3 stated bed rails were used for bed mobility and transfers to assist residents that had been screened by therapy. Bed rail reduction began about 2 months ago with therapy determining safety and need. Bed rail assessments were being completed quarterly. They were not sure if assessments were done before the bed rails were removed. There were residents on the unit that benefited from bed rail use.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/6/2024 at 2:55 PM, the Director of Maintenance stated the Director of Nursing instructed them to remove bed rails for resident safety. They believed every resident and family members were told about the removal. They stated the use of bed rails came with risks. They performed bed rail entrapment zone checks annually. The last one was done 12/2023, with no issues identified.</p> <p>During an interview on 8/7/2024 at 11:02 AM, the Director of Therapy stated bed rails were used to enhance independence with bed mobility. They enhanced bed mobility from sitting/ lying and getting up to the side of the bed. A bed rail screen was done on admission and quarterly to see if they would benefit the resident. From a therapy standpoint they were good but from a safety standpoint there were risks. They stated the facility had way too many bed rails, so therapy was supposed to look at them. They were then told they were all being removed. It was not fair to residents who could use them to promote independence with bed mobility. The goal was for residents to be at their highest functional level.</p> <p>During an interview on 8/7/2024 at 12:49 PM, the Director of Nursing stated there was a new policy for no bed rails in the building starting on 7/29/2024. The decision was made because the bed rail use in the facility was not being monitored as it should have been. They stated Centers for Medicare and Medicaid Services guidelines were used to develop the plan. They had Interdisciplinary Team Meeting with discussions to match their sister facility bed rail free policy. There were some instances where bed rails may have benefits. Therapy evaluated residents that may benefit from bed rail use and try alternatives such as over the bed trapeze. Residents should have been told they were going to be removed and offered alternatives to the bed rails before they were removed. If a resident did not have bed rails for independence with positioning, it could lead to increased risk for pressure ulcers and loss of dignity.</p> <p>During an interview on 8/7/2024 at 2:40 PM, the Administrator stated the bed rail policy changed on 7/29/2024. They were attempting to remove all bed rails that were not medically necessary. The goal was making sure residents were safe. The team talked at morning report, families were called, and residents were spoken to. They were not sure if all residents were notified before the bed rails were removed. Some residents could benefit from bed rail use for bed mobility.</p> <p>10NYCRR 415.5(e)(1)</p> <p>49448</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803</p> <p>44838</p> <p>Based on record review, observation, and interview during the recertification and abbreviated (NY00345143) surveys conducted 8/1/2024-8/7/2024, the facility did not ensure residents had a safe, clean, comfortable, and homelike environment for 3 of 3 resident units ([NAME], [NAME], and [NAME]) reviewed. Specifically, water temperatures were greater than 120 degrees Fahrenheit in shower rooms and resident bathrooms on [NAME] and [NAME] Units; The bathroom floor in room [ROOM NUMBER] on the [NAME] Unit was in disrepair and stained with a brown substance at the base of the toilet; resident wheelchairs on [NAME] and [NAME] Units were unclean; and the mechanical lifts on [NAME] and [NAME] Units were unclean with debris on the footplates.</p> <p>Findings include:</p> <p>The facility Admission Agreement documented the facility strived to provide an environment that was safe, clean, comfortable, and welcoming to its residents, families, and friends.</p> <p>The facility policy, Water Temperatures, dated 2/23/2022 documented water temperatures shall be maintained between 90 degrees Fahrenheit and 120 degrees Fahrenheit to assure resident safety. Building services performed daily inspections (to include weekends) of water temperatures. Any temperature that did not fall between 90 degrees Fahrenheit and 120 degrees Fahrenheit would be reported to a building service supervisor.</p> <p>The facility policy, Cleaning of Resident Rooms, dated 10/19/2022 documented the nursing facility would maintain clean, attractive surroundings without disrupting resident care.</p> <p>The facility policy, Creating a Work Order, dated 2/15/2021 documented that all team members could report needed repairs through an electronic communication system. Work orders were received and assigned to building services team members by the Building Services Director. Work orders were completed and signed off by the completing team member based on the type of repair, availability of parts, and necessity to arrange needed outside vendor services to complete the request.</p> <p>The facility policy, Wheelchair Safety and Care, dated 10/21/2022 documented cleaning of wheelchairs would take place when they were visibly soiled or upon a resident's request. Surface cleaning (of spills and surface dirt) should be completed using disinfectant wipes. For deeper cleaning, a wheelchair cleaning station was available in a designated location to thoroughly clean chairs.</p> <p>The facility policy, Use of a Mechanical Lift, dated 4/11/2024 documented lift care included: disinfection of lift surfaces after each use. The lifts should be wiped with a clean towel until dry.</p> <p>WATER TEMPERATURES</p> <p>Water temperatures (measured in degrees Fahrenheit) on the [NAME] Unit were as follows:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 8/2/2024 at 11:22 AM the bathroom sink beside the dining room was 126 degrees.</p> <p>- on 8/2/2024 at 11:39 AM room [ROOM NUMBER]'s bathroom sink was 121.1 degrees</p> <p>- on 8/2/2024 at 11:38 AM room [ROOM NUMBER]'s bathroom sink was 122 degrees.</p> <p>- on 8/2/2024 at 11:41 AM the shower room near room [ROOM NUMBER] was 121 degrees,</p> <p>- on 8/2/2024 at 11:47 AM the shower room (across from the dining room) sink was 124 degrees.</p> <p>During an observation on the [NAME] Unit on 8/2/2024 at 11:39 AM room [ROOM NUMBER]' s bathroom sink was 124.2 degrees.</p> <p>The June 2024, July 2024, and August 2024 water temperature log did not document any recorded temperatures greater than 120 degrees.</p> <p>During an interview on 8/2/2024 at 12:00 PM, Maintenance Worker #32 stated a couple of maintenance workers checked the water temperatures daily, usually a little before 8:00 AM. They tested on e room on each unit and checked both the water and the air temperatures. They tried to switch the rooms checked so it was random.</p> <p>During an interview on 8/2/2024 at 12:21 PM, Certified Nurse Aide #9 stated no residents had complained about too hot or too cold water. They would feel the water temperature before they used it for residents, and had the residents feel it as well. If the resident could not tell them, they touched the water and watched the residents' facial expressions. They were not aware of any residents that were burned from the shower room water. They stated they also tested resident rooms sink temperatures prior to washing their hands in the sink.</p> <p>During an interview on 8/7/2024 at 2:21 PM, the Maintenance Director stated the boiler was set at 115 degrees Fahrenheit. It was checked with a thermometer every day in three different locations on each unit. They had measured 126 degrees on the [NAME] Unit on 8/2/2024 at 11:22 AM and did not know where that spike in temperature came from. It was important that hot water be maintained properly to keep people from getting burned.</p> <p>ROOMS</p> <p>The following observation of resident room [ROOM NUMBER] were made:</p> <p>- on 8/2/2024 at 9:06 AM the floor was soiled with brown spots, there were dirty dishes at the bedside, a cold full bowl of soup was on the bedside table, and there was a gauze bandage on the floor. The bathroom floor had brown stains surrounding the base of the toilet, and the flooring was ripped and loose.</p> <p>- on 8/5/2024 at 9:34 AM the bathroom floor had brown stains, and the tile around the toilet was stained and loose.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 8/5/2024 at 2:29 PM the floor was spotted with brown spots, there was garbage on the floor, the bathroom toilet was leaking brown fluid around the toilet base, and the bathroom floor tiles were loose and ripped.</p> <p>A 4/25/2024 open work order created by Environmental Services Supervisor # 39 documented the floor was torn in resident room [ROOM NUMBER]'s bathroom.</p> <p>During an interview on 8/6/2024 at 10:51 AM, Housekeeper #40 stated they were responsible for cleaning the whole unit. There was no set schedule for room cleaning, and they were not able to get to each room daily. They emptied trash and cleaned each bathroom daily. They replenished toilet paper and paper towels and would put work orders in if they found a repair was needed. Sometimes they asked the Unit Secretary to call maintenance if there was a sink or toilet plugged and a response was needed right away. The resident in room [ROOM NUMBER] did not always allow housekeeping in their room. They stated they had put work orders in for the missing tile in that bathroom.</p> <p>During an interview on 8/6/2024 at 2:55 PM, the Director of Maintenance stated the housekeeping schedule consisted of cleaning all rooms. They partially cleaned if that was all they had time for. The work orders should be completed as timely as possible. There should have been a work order for the brown liquid seeping out at the bottom of a toilet and for loose flooring. During a follow-up interview on 8/7/2024 at 10:13 AM, they stated there was a work order placed for the damaged floor at the base of the toilet in room [ROOM NUMBER]'s bathroom. They were not sure why it had not been completed yet. The dangers of a damaged floor included difficulty keeping the floor clean and infection control issues. Bare concrete and loose flooring could increase the risk of slips, trips, or falls. They expected that work orders were completed as timely as possible.</p> <p>During an interview on 8/7/2024 at 10:37 AM, Environmental Services Supervisor # 39 stated housekeepers have a daily duty sheet with a space for work orders. They keep track of rooms done so they know where to pick up the next day. They received the duty sheets at day's end and entered any maintenance work orders into the computer. Maintenance took care of them when they were able. A damaged floor could be a tripping hazard or infection control issue. Especially in the bathroom moisture or other debris could get underneath which may promote mold/bacteria growth. They remembered putting a work order in for the floor in room [ROOM NUMBER] bathroom.</p> <p>WHEELCHAIRS</p> <p>The following observations of Resident #58 were made:</p> <p>- on 8/1/2024 at 12:09 PM in their room with their spouse visiting. Their wheelchair was unclean with food debris build up on the right side and a thick brownish substance on the frame.</p> <p>- on 8/2/2024 at 8:54 AM in the dining room, their wheelchair was unclean with food debris build up on the right side and a thick brownish substance on the frame.</p> <p>- on 8/5/2024 at 9:37 AM in the dining room, their wheelchair was unclean with food debris build up on the right side and a thick brownish substance on the frame.</p> <p>- on 8/6/2024 at 11:22 AM their wheelchair was unclean with food debris build up on the right side and a thick brownish substance on the frame.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 8/5/2024 at 9:34 AM Resident #43 was in their room sitting in their wheelchair. The seat was soiled with crumbs and there were scrambled eggs on the chair.</p> <p>The [NAME] unit wheelchair cleaning log was requested, and the facility was unable to provide a log for July/August 2024.</p> <p>During an interview on 8/6/2024 at 11:23 AM, Certified Nurse Aide #6 stated night shift certified nurse aides were assigned to wheelchair cleaning. Staff on any shift could clean wheelchairs if needed. Unclean wheelchairs were not homelike, dignified, and could be an infection control issue.</p> <p>During an interview on 8/6/24 at 11:37 AM Licensed Practical Nurse #4 stated the night shift was supposed to clean wheelchairs. There was a night shift schedule but no schedule for when there was 1 certified nurse aide scheduled. There was no July 2024 log for them to document wheelchairs were cleaned. The night nurse was supposed to make sure the log was completed.</p> <p>During an interview on 8/7/2024 at 11:39 AM, the Director of Nursing stated wheelchairs should be cleaned on the night shift and any time they were unclean. Clean wheelchairs provided dignity and a homelike environment. They should be clean for infection control issues.</p> <p>MECHANICAL LIFTS</p> <p>During an interview on 8/5/2024 at 9:44 AM, Resident # 59 stated the sit to stand lift they used was soiled. They stated it frequently had unidentified discolored spots present on the surface.</p> <p>During an observation on 8/5/2024 at 9:50 AM, the sit to stand lift on the [NAME] unit had dirt and debris on the foot plate.</p> <p>During an observation on 8/6/2024 at 8:59 AM, the sit to stand lift on the [NAME] unit had debris on the foot plate.</p> <p>During an interview on 8/7/2024 at 10:37 AM, Environmental Services Supervisor #39 stated it was not a housekeeping duty to clean mechanical lifts. It was a nursing responsibility and should be performed after each use.</p> <p>During an interview on 8/7/2024 at 11:27 AM, Certified Nurse Aide #23 stated mechanical lifts were cleaned by certified nurse aides after each use. They stated the sit to stand lift platform was really gross looking and should be cleaned. They used the bleach wipes in the clean utility room or on the nurse's cart to clean the lifts.</p> <p>During an interview on 8/7/2024 at 11:56 AM, Certified Nurse Aide #24 stated they cleaned lifts with disinfectant wipes after every use to prevent spreading germs. The foot plate was cleaned when it was visibly soiled, and crumbs on the foot plate should be cleaned off.</p> <p>10 NYCRR 415.29 (f)(6), (j)(1)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448</p> <p>Based on record review and interview during the recertification and abbreviated (NY00348869) surveys conducted 8/1/2024-8/7/2024, the facility did not permit a resident to return to the facility after they were hospitalized for 1 of 1 resident (Resident # 360) reviewed. Specifically, Resident #360 was sent to the hospital for evaluation for behaviors, was medically cleared by the hospital to return to the facility, was transported back to the facility, and was refused return to the facility.</p> <p>Findings include:</p> <p>The facility's undated Admission Agreement documented a resident may have a medical illness or other matter that required them to be away from the facility for some period. All nursing home residents had the option to have their bed kept available for their return.</p> <p>The facility policy, Resident Transfer and Discharge, effective 2/22/2029, documented emergency transfers to an acute care facility were considered a facility-initiated transfer, not a discharge. The resident must be permitted to return to the facility if the facility has evidence that the resident status at the time the resident seeks to return to the facility meets the required criteria.</p> <p>Resident #360 was admitted to the facility with diagnoses including dementia, anxiety, and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain and mental status). The entry Minimum Data Set assessment documented the resident was admitted on [DATE] from a short-term general hospital.</p> <p>The 7/19/2024 at 1:04 PM hospital discharge summary documented the resident was hospitalized [DATE]-[DATE]. The resident's primary discharge diagnoses were acute renal (kidney) failure with a secondary diagnosis of acute metabolic encephalopathy and vascular dementia with hyperactive delirium (increased agitation). Due to progression of their dementia process it was determined they were discharged to a skilled nursing facility for continued care.</p> <p>The Admission Record Face sheet documented the resident was their own responsible party and their spouse was their emergency contact.</p> <p>The unsigned 7/19/2024 Nursing Admission Assessment documented the resident was admitted to the facility from the hospital for dementia and deconditioning. The resident was confused and had a short-term memory problem. The resident was angry, aggressive, resistive, and had disorganized thinking. The resident was totally dependent for bed mobility, transfers, did not walk, and used a wheelchair.</p> <p>Nursing notes dated 7/19/2024-7/20/2024 documented the resident was agitated, yelling, and throwing items.</p> <p>A 7/20/2024 at 7:29 PM Registered Nurse Supervisor #20 progress note documented they received an order for IM (intramuscular) Haldol (antipsychotic) 5 milligrams one time from Nurse Practitioner #33.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	
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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 7/21/2024 at 6:03 PM Registered Nurse Supervisor #20 progress note documented the resident has not allowed staff to provide care since admission. The resident threw their lunch tray and would not eat or drink. The resident was provided as needed medication for anxiety. The on call provider Physician Assistant #17 was called and a message was left.</p> <p>A 7/21/2024 at 6:41 PM Registered Nurse Supervisor #20 progress note documented a telephone order was received from Physician Assistant #17 to send the resident to the emergency room for evaluation.</p> <p>A 7/21/2024 at 7:38 PM Registered Nurse Supervisor #20 progress note documented Emergency Medical Services and police responded to transfer the resident. The resident's family member was aware on was on the way to facility. When family arrived, the resident was transferred onto the stretcher and left the building at 7:57 PM. There was no documented evidence the discharge and plan to return to the facility was discussed with the family members.</p> <p>The 7/22/2024 emergency department medical decision-making note by the emergency room physician documented the resident's increased agitation was likely due to a urinary tract infection and the resident was discharged with a plan for primary care provider follow up. The resident was given a prescription for levofloxacin (antibiotic) and strict return precautions for fever.</p> <p>The emergency department patient care timeline from 7/21/2024-7/22/2024, documented attempts to call a medical report on the resident's condition to the facility were made on 7/22/2024 at 12:18 AM and again at 12:34 AM but the telephone at the facility was not answered. The resident was discharged from the emergency department back to the facility at 12:55 AM.</p> <p>The 7/22/2024 Emergency Medical Service report documented the resident left the hospital at 12:58 AM and arrived at the facility at 1:11 AM. The crew attempted to use the facility intercom system to reach staff to let them in and knocked on the front door without success. When they could not reach the facility after approximately 15 minutes, they called their dispatcher. At 1:25 AM they received a call back from their dispatcher who told them they had contacted Registered Nursing Supervisor #20 on the third telephone attempt, who reported to them the resident was difficult and they could not deal with it. Emergency Medical Services was advised to return the resident to the hospital emergency department. The crew again attempted to call the Nursing Supervisor to provide additional information, but the phone was not answered. The crew then called the emergency room Charge Nurse #21 at the hospital and explained that the facility refused to accept the resident back and they would be returning the resident to the emergency department. At 1:47 AM the resident returned to the hospital.</p> <p>There were no documented facility medical, nursing, social work, or psychiatry notes regarding the resident's discharge from the facility.</p> <p>During an interview on 8/6/2024 at 10:30 AM Registered Nurse Supervisor #20 stated when they received a telephone call from Emergency Medical Services, they told them Resident #360 was no longer a resident at the facility. They thought when a rehabilitation resident was sent out for evaluation, they were discharged , so they discharged them out of the electronic medical system. They did not contact the hospital or speak with anyone at the hospital. The resident's family member was present when they were transferred to the hospital, but they did not communicate to them that the resident was not allowed to return to the facility. They stated they always had the supervisor telephone in their possession.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/2024 at 12:54 PM the resident's family member stated they were at the facility when the resident was transferred to the hospital and was at their bedside in the emergency department until it was determined the resident was cleared for discharge back to the facility. They left the hospital. They were not notified by anyone at the facility that the resident was not allowed to return until a few days after that when they received a call from The Director of Admissions to pick up a box of the resident's personal belongings. The resident now resided with them at their home.</p> <p>During an interview on 8/6/2024 at 1:16 PM the Director of Admissions stated the Registered Nurse Supervisor #20 called them on 7/21/2024 and told them the resident was sent to the emergency department for behaviors and the plan was for the resident not to return to the facility. They backed up the Nursing Supervisor's decision. They knew the resident had behaviors but accepted them for admission because they were a former employee. Registered Nurse Supervisor #20 should have told the hospital in nurse-to-nurse report that they were not to return to the facility. The nurse that sent the resident out was responsible to communicate with the hospital. They had communicated with the social worker at the hospital on 7/22/2024 during business hours when they returned to work and explained that the resident could not return to the facility until their behaviors improved with medication adjustments and they could review them again for future admission.</p> <p>During an interview on 8/6/2024 at 1:42 PM the Director of Nursing stated they were notified on 7/21/2024 by Registered Nurse Supervisor #20 that the resident was transferred to the hospital, they were not taking them back, and had called the Director of Admissions that night and told them. The resident had difficult behaviors and verbal aggression. They expected Registered Nurse Supervisor #20 to communicate with the hospital. Resident #360 had dementia and their communication was not great. Registered Nurse Supervisor #20 told them they did not speak to the hospital but provided their phone number on the paperwork. All after hour calls to the facility went to the Nursing Supervisor's phone. They looked through the phone log and could not verify any communication with the hospital for 7/21/2024.</p> <p>During an interview on 8/6/2024 at 3:28 PM with the emergency room Charge Nurse #21, they stated the resident was seen and evaluated in the emergency department, was diagnosed with a urinary tract infection, and medically cleared to return to the facility. Attempts were made to call a nurse-to-nurse report, but the phone was not answered. Their hospital policy stated if attempts at report with a facility were unsuccessful, the resident was returned because there were always staff at the facility. The Emergency Medical Service crew reported to them the facility refused to take the resident back and they returned to the hospital. There was no communication between the facility and the hospital even after the facility refused the resident and sent them back to the hospital.</p> <p>The resident's discharge/ transfer notice was requested from the facility on 8/6/2024 at 5:15 PM. On 8/7/2024 at 2:33 PM, the requested document had not yet been received and the Administrator and the Health Information System Director verbally confirmed they did not have this document.</p> <p>The resident's transfer/ discharge notice was received from the facility at 8/7/2024 at 3:28 PM. The form was not signed or dated.</p> <p>10NYCRR 415.3(h)(4)(iii)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40803</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 8/1/2024-8/7/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 3 of 5 residents (Residents #48, #57, and #88) reviewed. Specifically, Resident #48 did not receive a lid for their hot beverage cups as care planned and did not have their palm guard (contracture management device) applied as care planned; Resident #57 did not have their palm guards applied as care planned; and Resident #88 did not have their elastic tubular compression bandage (Tubigrip) applied as ordered.</p> <p>Findings include:</p> <p>The facility policy, Orthotic Devices, revised 8/1/2023, documented the purpose of orthotic devices was to maintain joint range of motion and elasticity and provide proper body alignment. The rehabilitation department would provide orthotic devices for residents who could benefit from their use. Nursing staff would be instructed in the proper position of the extremity, proper application of the device, wearing schedule, precautions, and goal/purpose of the device. The comprehensive care plan would be updated to include any changes in status, goals, and recommendations, to reflect the wearing of the orthotic device.</p> <p>1) Resident #48 had diagnoses including dementia and muscle weakness. The 6/27/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, did not reject care, had impairment to 1 upper extremity, required setup or clean-up assistance with eating, and received a therapeutic diet.</p> <p>The Comprehensive Care Plan revised 7/12/2024 documented the resident had self-feeding difficulty, received a regular diet with thin liquids, and used a lip plate, Dycem mat (anti-slip material), and mugs with lids for hot beverages.</p> <p>The undated care instructions documented the resident received a regular diet with thin liquids, required supervision at meals, and was to be provided lip plate, Dycem mat, mugs with lids for hot beverages.</p> <p>The resident was observed in the dining room drinking hot beverages from a mug without a lid on 8/1/24024 at 12:23 PM and on 8/5/2024 at 12:13 PM.</p> <p>During an observation on 8/6/2024 at 12:43 PM, Certified Nurse Aide #6 provided the resident with a hot beverage in a mug without a lid. The resident drank 100% of their hot beverage. Their meal ticket documented they were to receive a mug with a lid for their hot beverages.</p> <p>During an interview on 8/6/2024 at 12:59 PM, Certified Nurse Aide #6 stated they provided the resident with their hot beverage but did not put a lid on the mug. The resident was supposed to have a lid on their mug for all hot beverages. They thought the resident was supposed to have a lid on their hot beverage so they could not spill it on themselves. Staff were supposed to review the meal tickets prior to serving the residents to ensure they received the correct items on their meal tray.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/2024 at 2:40 PM, Licensed Practical Nurse #5 stated staff should review the residents' meal tickets prior to serving the resident to ensure they received the correct diet and adaptive equipment at mealtimes. Resident #48 was supposed to receive a lid for their hot beverages because they sometimes spilled their drinks. The lid helped to prevent the drink from spilling on the resident or the table.</p> <p>During an interview on 8/7/2024 at 10:04 AM, Registered Dietitian #12 stated staff should review the meal tickets prior to serving the residents to ensure they received the correct food items and equipment. The resident's meal ticket indicated they were supposed to have a lid on their hot beverages. This had been in place on their meal pattern profile since September 2018.</p> <p>During an interview on 8/7/2024 at 12:02 PM, the Director of Nursing stated staff should be reading the meal tickets to ensure all items were present and correct prior to serving the resident. If items were missing, they should let a nurse know.</p> <p>2) Resident #57 had diagnoses including dementia, contracture (tightening of the muscles, tendons, and joints) of the right arm, and muscle weakness. The 7/4/2024 Minimum Data Set Assessment documented the resident had severely impaired cognition, did not reject care, had impairment to both upper extremities, and was dependent for dressing.</p> <p>The 5/14/2024 physician order documented the resident was to be screened and/or evaluated for occupational therapy.</p> <p>A 5/14/2024 Registered Nurse Unit Manager #3 progress note documented a referral was put in for contracture management.</p> <p>The 5/14/2024 Occupational Therapist #30 Evaluation & Plan of Treatment documented the resident had contractures of the left and right hands and was referred for skilled occupational therapy services to address contracture of bilateral hands. Goals included the resident would safely wear a palm guard on the left hand for up to 8 hours with minimal signs and symptoms of redness, swelling, discomfort, or pain. The caregiver would increase compliance with orthotic management instructions to dependence in order to maintain joint integrity and improve skin integrity and hygiene. Recommendations included palm guard with finger separators on right hand and palm guard on left hand.</p> <p>The revised 5/16/2024 Comprehensive Care Plan documented the resident had an activity of daily living self-care performance deficit related to decreased mobility, pain, and contractures. Interventions included the resident was to wear a palm guard on the left hand, and a palm guard with finger separators on the right hand.</p> <p>The undated care instructions documented to provide a palm guard for the left hand and a palm guard with finger separators for the right hand. The resident was dependent for dressing.</p> <p>The resident was observed without a palm guard on the left hand or a palm guard with finger separators for the right hand:</p> <p>- on 8/1/2024 at 12:03 PM sitting in their recliner chair; at 12:55 PM, while being assisted with their lunch meal; and at 2:41 PM, lying in bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 8/2/2024 at 8:50 AM, while being assisted with their breakfast meal.</p> <p>- on 8/5/2024 at 9:32 AM, while being assisted with their breakfast meal; and at 1:35 PM, while seated in their recliner in their room.</p> <p>During an interview on 8/5/2024 at 1:35 PM Certified Nurse Aide #9 stated the resident did not have any orthotic devices for their hands at this time. During a follow up interview at 2:40 PM, they stated the care instructions alerted staff if a resident required any palm guards or splints. If a resident was not provided with their palm guards or splints as care planned their contractures could worsen. If a resident refused to wear their splint or palm guard, they should let the nurse know so they could attempt to apply the device and document any refusals. There was nowhere for the certified nurse aides to document the device was applied or refused. They stated the resident was supposed to have devices in both of their hands because of their contractures, but they could not find them. The resident did not refuse care. They stated they did not tell anyone they were unable to find the devices.</p> <p>During an interview on 8/5/2024 at 2:50 PM Licensed Practical Nurse Assistant Unit Manager #4 stated staff should review the care instructions daily. It was important to follow the care instructions for resident safety. The care instructions included information on palm guards or splints. It was important to apply contracture devices as care planned to prevent worsening of the contractures and skin breakdown. If staff were unable to find the contracture devices or the resident was refusing to wear the devices, staff should alert a nurse so they could approach the resident to encourage them to wear the device or document the refusal. There was no place to document the device was applied or refused in the electronic medical record. The nurses could enter a progress note if the device was refused or missing. They should also contact the therapy department to alert them a replacement device was needed. They were not made aware the resident's contracture devices were missing.</p> <p>3) Resident #88 had diagnoses including edema (swelling caused by fluid). The 6/35/2024 Minimum Data Set assessment documented the resident was cognitively intact, required partial/moderate assistance with lower body dressing and putting on/taking off footwear, had edema, received a diuretic (water pill), and did not reject care.</p> <p>The Comprehensive Care Plan initiated 3/27/2024 and revised 7/17/2024 documented the resident had a history of edema blisters to both lower extremities (legs). Interventions did not include the use of Tubigrips.</p> <p>The 4/25/2024 physician order documented apply Tubigrips in the morning and remove in the evening.</p> <p>Resident #88 was observed at the following times:</p> <p>- On 8/1/2024 at 3:34 PM, in their room sitting up in their wheelchair eating a banana. They were wearing shorts and their Tubigrips were in the chair across from their bed.</p> <p>- On 8/5/2024 at 11:07 AM and at 11:52 AM, in their room sleeping in their recliner chair with their legs elevated on their footrest. Their Tubigrips were in the chair across from their bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The August 2024 Treatment Administration Record documented Tubigrips on in the AM, off at hour of sleep every day with a start date of 4/25/2024. The Tubigrips were documented as put on in the morning by Licensed Practical Nurse #27 on 8/1/2024 and 8/5/2024.</p> <p>During an interview on 8/5/2024 at 12:11 PM, Licensed Practical Nurse #27 stated Tubigrips were used to reduce swelling and promote circulation. They were put on in the morning and taken off in the evening. Completion of this task was documented in the Treatment Administration Record and if it was documented as completed it meant the Tubigrips were on. Sometimes the certified nurse aides put the Tubigrips on, but it was their responsibility to check they were on. They had not verified placement of the Tubigrips for Resident #88 yet, but they signed it off. Resident #88 wore the Tubigrips for edema and it was important that they were worn daily. If the resident did not wear them, they could retain fluid and their legs could swell. The resident did not refuse care.</p> <p>During an interview on 8/5/2024 at 12:21 PM, Registered Nurse Unit Manager #26 stated they expected nurses to follow orders. If something was documented as completed in the Treatment Administration Record it meant it was done. The certified nurse aides could place the Tubigrips, but the nurse was ultimately responsible and should verify they were on before signing as completed. It was not appropriate to document the treatment was completed prior to verification of placement of the Tubigrips. Resident #88 had swelling to their legs and had a history of worsening edema with blisters and discomfort and the Tubigrips were utilized to prevent reoccurrence. Without routine use of the Tubigrips as ordered the resident's edema could get worse.</p> <p>10 NYCRR 415.12</p> <p>49448</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838</p> <p>Based on observation, record review, and interview during the recertification survey conducted 8/1/2024-8/7/2024 the facility did not ensure residents with pressure ulcers or at risk for pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 4 residents (Residents #14 and #312) reviewed. Specifically, Residents #27 and #312 had specialty air mattresses (mattresses that provides air flow to relieve pressure) that did not have individualized settings and were not monitored to ensure appropriate settings were used.</p> <p>Findings include:</p> <p>The facility policy, Prevention of Pressure Ulcers/Injuries, dated 5/24/2024, documented the purpose was to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Appropriate support surfaces were selected based on the resident's mobility, continence, skin moisture and perfusion (blood flow), body size, weight, and overall risk factors. These may include (but were not limited to):</p> <ol style="list-style-type: none"> 1. Specialty mattresses designed to help reduce the amount of pressure that existed between the bed surface and the resident. These were specifically constructed and designed to enhance comfort and better distribute weight. Mattresses could be made of foam, gel, air columns/pockets, or water columns/pockets. Mattress Overlays were secured to a mattress and provided additional support. <p>The manufacturer's guidelines for the air mattress were requested from the facility and were unable to be located.</p> <p>1) Resident #14 had diagnoses including multiple sclerosis (a disease of the central nervous system), diabetes, and paraplegia (paralysis of the legs). The 7/17/2024 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, required substantial assistance for bed mobility, was dependent for transfers, had an indwelling catheter, was at risk for developing pressure ulcers, did not have pressure ulcers, and had a pressure reducing device for the bed.</p> <p>The comprehensive care plan last revised 11/20/2023 documented the resident had a self-care deficit due to multiple sclerosis with limited mobility. They required extensive assistance for bed mobility and was dependent on a mechanical lift for transfers.</p> <p>The comprehensive care plan last revised 12/7/2023 documented the resident was at risk for skin impairment related to impaired mobility, urination from penis, and altered sensation in lower extremities. On 12/5/2023 the resident had a deep tissue injury (purple/[NAME] discoloration due to damage of underlying tissue) to the right sacrum (bony structure at base of spine) surrounded by moisture associated skin damage. Interventions included turn and position every 2-3 hours when in bed, float heels always when in bed, and a pressure reducing/relieving mattress on the bed.</p> <p>A risk assessment tool used to predict the likelihood pf pressure ulcers was completed 5/5/2024, 6/5/2024, 7/5/2024, and 7/13/2024 and documented the resident was at high risk for the development of pressure ulcers.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There were no documented physician orders for an alternating pressure mattress. There were no documented settings or monitoring plans in place for the alternating pressure mattress. The August Medication Administration and Treatment Administration Records did not include the use of an alternating pressure mattress that included settings and monitoring.</p> <p>The resident's weight summary documented a weight of 203.3 pounds on 8/1/2024.</p> <p>The following observations were made:</p> <ul style="list-style-type: none"> - on 8/1/2024 at 11:31 AM the resident was in bed, their feet appeared to be higher than their head, an alternating pressure mattress was in place and on and was set at 580 pounds, alternate every 10 minutes. - on 8/2/2024 at 12:01 PM the resident's alternating pressure mattress was in place and on and was set at 580 pounds, alternate every 10 minutes. - on 8/5/2024 at 9:55 AM the resident's alternating pressure mattress was in place and on and was set at 580 pounds, alternate every 10 minutes. <p>During an interview on 8/7/2024 at 11:07 AM, Licensed Practical Nurse #22 stated pressure relieving interventions included frequent repositioning. Air mattresses were also used, some of which provided repositioning. Resident #14 had an air mattress. Maintenance placed air mattresses at the request of nursing, and they were not sure who set controls. They checked for them being on when they were in the room but did not document anywhere. Resident #14 had a pressure area in the past which placed them at increased risk for developing pressure areas. They also had limited ability to reposition themselves independently. They were not sure what the pressure mattress should be set at. They observed the resident's mattress and stated it was set at 580 pounds, comfort, alternate every 10 minutes. The resident did not weigh 580 pounds so the air pressure in the mattress would not be appropriate.</p> <p>2) Resident #312 had diagnoses including pressure ulcers of right buttock. The 7/18/2024 Minimum Data Set assessment documented the resident had intact cognition, was dependent on staff for bed mobility and transfers, had an indwelling catheter, was at risk for developing pressure ulcers, and had no unhealed pressure ulcers.</p> <p>The comprehensive care plan initiated 7/12/2024 documented the resident had a self-care performance deficit related to decreased mobility/recent hospitalization . The resident was dependent for bed mobility and required extensive assistance of 2.</p> <p>The comprehensive care plan updated 7/26/2024 documented the resident had actual impairment to skin integrity of the buttocks related to moisture associated skin damage, an unstageable area to the left buttock, and a Stage 2 (partial loss of top layer of skin) area to the right buttock. Interventions included an air mattress on the bed, offer repositioning to resident every 2 hours, and the resident would often refuse to turn/reposition.</p> <p>A 7/27/2024 physician order documented check placement of air mattress every shift and ensure proper functioning every shift. There were no documented settings in place for the air mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 8/2024 Treatment Administration Record documented check placement of air mattress every shift and ensure proper functioning every shift. The air mattress was checked as in place and properly functioning 8/1/2024-8/6/2024.</p> <p>The resident's weight summary documented a weight of 225.2 pounds on 8/1/2024.</p> <p>The following observations were made:</p> <ul style="list-style-type: none"> - on 8/5/2024 at 9:29 AM the resident was sitting on the edge of the bed; the air mattress overlay control light was on and set midway between minimum and maximum. The resident stated this mattress was a little more comfortable than the last one. - on 8/7/2024 at 11:26 AM the air mattress overlay on the resident's bed was set midway between minimum and maximum, and the light was on as functioning. <p>During an interview on 8/7/2024 at 11:27 AM, Certified Nurse Aide #23 stated they should check to make sure the air mattresses were on, and in place. They were not sure what they should be set at. The air mattress overlay for residents was set up by maintenance.</p> <p>During an interview on 8/7/2024 at 11:38 AM, Registered Nurse Unit Manager #26 stated pressure reducing devices included cushions in chairs and mattresses all had pressure reducing properties. Residents at increased risk for pressure injury got air mattress overlays or alternating pressure mattresses. Maintenance set up the mattresses, nursing decided on the settings based on weight, need for alternating or not. Resident #312's air overlay mattress was set midway between minimum and maximum, and they were not sure who set the air flow. They thought it was set for resident comfort to reduce pressure. Every time a resident was cared for, the mattress should be checked for functionality.</p> <p>During an interview on 8/7/2024 at 12:49 PM, The Director of Nursing stated pressure reducing devices used were wheelchair cushions, air mattress overlays, and low air loss alternating mattresses. The purpose was to relieve pressure for residents who had open areas, skin issues, or were at increased risk for pressure injury. The need was identified by nursing, and maintenance put the mattress on the bed. A registered nurse decided the settings and they were typically based on weight. They would not want it to be set above their weight as it would be too firm and may place too much pressure on the skin. They felt it should be documented on the care plan and the Kardex. There should be a spot on the administration record for nursing to check. The settings needed to be resident specific, a resident who weighed 200 pounds should not have their air mattress set at 500 pounds. The goal was to help heal or prevent pressure areas.</p> <p>10NYCRR 415.12(c)(1)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>40803</p> <p>Based on observation, record review, and interview during the recertification survey conducted 8/1/2024-8/7/2024 the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for 2 of 5 residents (Residents #44 and #106) reviewed. Specifically, Resident #44's bed was not maintained in the low position as care planned; and Resident #106's meal was reheated in a microwave by nursing staff and the temperature was not checked prior to serving the meal to the resident.</p> <p>Findings include:</p> <p>The facility policy, Managing Falls and Fall Documentation, last reviewed 5/22/2024 documented team members would seek to identify and document resident risk factors and identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and try to minimize complications from falls.</p> <p>The facility policy, Food Safety, last reviewed 3/18/2024 documented accurate food thermometers were available and used by all food employees during storage, preparation, display, service, and transportation. Thermometers must be accurate to at least +/- two degrees and sanitized before use. All food products were required to be cook to internal temperature; reheat foods rapidly to 165 degrees Fahrenheit, minimum temperature for minimum of 15 seconds; and hold hot foods at 135 degrees Fahrenheit or above. The policy did not include instructions for safely reheating resident meals in microwaves.</p> <p>The facility policy, Food from Outside Sources, reviewed 10/25/2022, documented the Food from Outside Temperature Log must be completed when reheating food for residents. The form was located near the microwave in each pantry. The policy did not include instructions for safely reheating resident meals in microwaves and recommended temperatures for safety.</p> <p>1) Resident #44 had diagnoses including Alzheimer's disease, muscle weakness, and unsteadiness on feet. The 5/23/2024 Minimum Data Set assessment (a health screening tool) documented the resident had severely impaired cognition, did not reject care, was dependent for transfers from sitting to standing and chair to bed transfers, did not walk, used a manual wheelchair, and did have any falls since admission or the prior assessment.</p> <p>The 6/1/2024 Incident Investigation completed by Registered Nurse Supervisor #31 documented the resident had an unwitnessed fall at 6:00 AM while attempting to self-transfer out of bed to the wheelchair. The resident was found lying on the floor on their back. The resident had no apparent injuries, denied pain, and denied hitting their head on the floor. Neurological checks were at baseline. The resident was non-ambulatory and was put back to bed with a mechanical lift. Changes were made to care plan to have a therapy evaluation for transfers and ambulation, frequent observations and room checks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 6/1/2024 Comprehensive Care Plan documented the resident had an actual fall related to dementia, and poor safety awareness. Interventions included frequent checks while in their room; move the resident to area with better visual access to the nurse's station, and physical therapy referral for transfers and ambulation.</p> <p>The 6/15/24 Incident Investigation completed by Registered Nurse Supervisor #32 documented the resident had an unwitnessed fall at 10:40 AM, while attempting to get out of bed to go to lunch. The resident was found lying on their back next to their bed. Changes implemented to prevent reoccurrence was to put the bed in the lowest position.</p> <p>On 6/16/2024 the Comprehensive Care Plan for falls included an additional intervention to place the bed in the lowest position.</p> <p>The undated care instructions (Kardex) documented the resident's bed was to be in the lowest position.</p> <p>The following observations of Resident #44's bed were made:</p> <ul style="list-style-type: none"> - On 8/1/2024 at 11:01 AM and 2:25 PM, the bed was at mid-thigh height. - On 8/2/2024 at 8:35 AM, the resident was in bed and the bed was at knee height. - On 8/2/2024 at 10:07 AM and 10:55 AM, the resident was in bed and the bed was at knee height. - On 8/2/2024 at 12:07 PM, the resident was in bed with their door closed and the bed was at hip height. - On 8/5/2024 at 9:20 AM, the resident was in bed and the bed was at knee height. <p>During an interview on 8/6/2024 at 11:02 AM, Certified Nurse Aide #7 stated they assisted Resident #44 today with their care. The resident's bed was not in the low position. The bed should be in the lowest position because the resident had tried to get out of bed. If the resident bed was not in the low position, it would be a safety issue and it was important to follow the resident's care plan for their safety.</p> <p>During an interview on 8/6/2024 at 11:46 AM, License Practical Nurse #5 stated the Kardex would provide instructions for safety such as a low bed position. A low bed position was usually an intervention due to falls. If the bed was care planned to be in low position, it would be a safety risk if it was not in the lowest position. Resident #44 was not able to raise or lower their own bed.</p> <p>During an interview on 8/6/2024 at 2:49 PM, Licensed Practical Nurse Assistant Nurse Manager #4 stated the resident was care planned for low bed for falls. The resident preferred to stay in their room. The care plan should be followed for safety reasons. All the staff should be checking to ensure the bed was set at the proper height. If the resident was in bed and not eating or drinking the resident's bed should be in the lowest position.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/7/2024 at 11:52 AM, the Director of Nursing stated the registered nurse should determine the fall interventions required for a resident. If the intervention was for a low bed, the bed should always be in the lowest position. The resident should not be left in their room alone if the bed was not in the low position. It was important to follow the care plan for the safest care of the resident.</p> <p>2) Resident #106 had diagnoses including dementia and moderate protein-calorie malnutrition. The 6/28/2024 Minimum Data Set assessment documented the resident had moderately impaired decision making ability and was dependent on staff for most of activities of daily living including eating.</p> <p>The comprehensive care plan initiated 6/26/2024 documented the resident had an activities of daily living self-care performance deficit related to aggressive behavior, Alzheimer's confusion, impaired balance, and limited mobility. Interventions included the resident required substantial/maximum assistance of one staff for eating; sit up in their wheelchair for all meals; and give one items at a time to limit distractions.</p> <p>The undated care instructions (Kardex) documented the resident required substantial to maximum assistance of one staff for eating and the resident should be in their wheelchair for all meals.</p> <p>During an observation and interview on 8/5/2024 at 1:10 PM, Certified Nurse Aide #8 heated up the resident's meal items (Salisbury steak, mashed potatoes, and peas) for 15 seconds and covered the meal to bring out to the resident. They did not take the temperature of the food prior to serving the resident. Certified Nurse Aide #8 stated they just wing it when they warmed up food in the microwave. The food was still warm, so they just heated it up. They did not have training on how to heat food in the microwave. They stated they would test the temperature of the food on their wrist or hover their hand over the food. They were not sure if there was a thermometer in the kitchen. They stated it was important to check temperatures of food to prevent burns and for food safety, but they had never noticed any reheating instructions.</p> <p>During an interview on 8/5/2024 at 1:24 PM, Food Service Aide #33 stated there were no thermometers to check the temperatures of food heated in the microwave. They should not heat food in the microwave. There were no reheating instructions. The resident should have received a new tray if the food was not warm enough and nursing staff should just request another tray. Food that was heated in the microwave could be too hot.</p> <p>During an interview on 8/7/2024 at 11:59 AM, the Director of Nursing stated they were not sure about nursing staff heating food in the microwave. They stated staff that heat food prior to serving the resident should have received education for safety reasons to prevent burns to the resident.</p> <p>10 NYCRR 415.12(h)(2)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49448</p> <p>Based on observation, record review, and interview during the recertification survey conducted 8/1/2024-8/7/2024, the facility did not ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for 1 of 1 resident (Resident #88) reviewed. Specifically, Resident #88 received oxygen at a higher flow rate than the physician ordered.</p> <p>Findings include:</p> <p>The facility policy, Oxygen Concentrator Initiation/ Discontinuation, reviewed 12/15/2020 documented the licensed nurse was responsible to ensure the physician orders for the resident were checked. The flow rate was charted in the resident record every shift.</p> <p>Resident #88 had diagnoses including chronic obstructive pulmonary disease (lung disease), pleural effusion (fluid buildup between the lung and the chest wall) and need for assistance with personal care. The 6/25/2023 Minimum Data Set assessment documented the resident was cognitively intact, had shortness of breath, and required oxygen therapy.</p> <p>The comprehensive care plan initiated 4/15/2024 and revised 6/14/2024 documented the resident had oxygen therapy related to shortness of breath. Interventions included medications to be given as ordered, monitor for signs and symptoms of respiratory distress and report to physician as needed. Oxygen settings 2 liters via nasal prong.</p> <p>The 4/17/2024 physician order documented the resident was to receive oxygen via nasal cannula at 2 liters per minute continuously.</p> <p>Resident #88 was observed at the following times:</p> <ul style="list-style-type: none"> - On 8/1/2024 at 3:34 PM, in their room sitting up in their wheelchair eating a banana. They were receiving oxygen from an oxygen concentrator via nasal cannula that was set at 4 liters. - On 8/2/2024 at 9:07 AM, in their room sitting in their recliner chair. They were receiving oxygen from an oxygen concentrator via nasal cannula that was set at 4 liters. - On 8/2/2024 at 10:32 AM, in their room sitting in their recliner chair visiting with family. They were receiving oxygen from an oxygen concentrator via nasal cannula that was set at 4 liters. - On 8/5/2024 at 11:07 AM, in their room sleeping in their recliner chair. They were receiving oxygen from an oxygen concentrator via nasal cannula that was set at 4 liters. <p>The August 2024 Treatment Administration Record documented oxygen at 2 liters via nasal cannula continuous every shift with a start date of 4/17/2024. Licensed Practical Nurse #27 documented the resident's oxygen was administered via nasal cannula at 2 liters per minute on 8/1/2024, 8/2/2024, and 8/5/2024 during the day shift.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/5/2024 at 12:11 PM Licensed Practical Nurse #27 stated the flow rate of a resident's oxygen was in the physician orders and documented in the Treatment Administration Record. Settings were checked once per shift and if it was documented as completed, it meant the flow rate was correct. Too much oxygen could be bad for the resident's lungs and oxygen levels in the blood. Resident #88 had an order for oxygen at 2 liters per minute. They had already documented in the Treatment Administration Record, but they had not checked the oxygen flow rate, and they should have prior to documenting. They did not know the resident's concentrator was set a 4 liters per minute for several days.</p> <p>During an interview on 8/5/2024 at 12:21 PM Registered Nurse Unit Manager #26 stated they expected nurses to follow orders, and oxygen required a physician order. Oxygen administration was signed by the nurses in the Treatment Administration Record and if it was documented as completed, it meant the nurse checked to make sure the setting was appropriate. It was not appropriate it was documented if it was not checked. Oxygen ordered flow rates could change and accuracy of the flow rate was important to be checked. For residents with chronic obstructive pulmonary disease, it was especially dangerous if they received higher than ordered oxygen flow rates. This could cause shortness of breath, dizziness, or they could hyperventilate (breathing at an abnormally rapid rate). Resident #88 had chronic obstructive pulmonary disease and had an order for oxygen at 2 liters per minute, and it was not appropriate they received 4 liters per minute.</p> <p>10NYCRR 415.12(k)(6)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 44838</p> <p>Based on record review, observation, and interview during the recertification survey conducted 8/1/2024-8/7/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meals (lunch meal on [NAME] and [NAME] Units on 8/5/2024) reviewed. Specifically, food was not served at palatable and appetizing temperatures for the lunch meals on [NAME] and [NAME] Units on 8/5/2024.</p> <p>Findings include:</p> <p>The facility policy, Resident Meal Service, dated 10/25/2022 documented each resident was provided with an appealing, tasteful, nutritious meal served in a timely manner and in a pleasant environment.</p> <p>The facility policy, Food Safety, originally dated 1/21/2016 and reviewed 3/18/2024 documented all Temperature Controlled for Safety foods must meet the following temperature requirements during storage, preparation, display, service, and transportation:</p> <p>Hot foods, hold foods at 135 degrees Fahrenheit; cold foods hold foods at 40 degrees Fahrenheit or below.</p> <p>During an observation on 8/5/2024 at 12:54 PM on the [NAME] Unit, Resident #106's lunch tray was sitting on the counter ready to be served and was planned to be used as a test tray. At 1:10 PM Certified Nurse Aide #8 heated food from the resident's tray in the microwave for 15 seconds. A replacement tray was requested for the resident. The temperatures of the microwaved food were measured as follows: the Salisbury steak was 127 degrees Fahrenheit, the mashed potatoes were 122 degrees Fahrenheit, the peas were 117 degrees Fahrenheit, the Mighty Shake (nutritional supplement) was 50 degrees Fahrenheit, and the cranberry juice was 56 degrees Fahrenheit.</p> <p>During an observation on 8/5/2024 at 12:49 PM on the [NAME] Unit, Resident #363's lunch tray was selected as a test tray and a replacement was requested. The following food temperatures were measured: peas were 100 degrees Fahrenheit, cheddar mashed potatoes were 111degrees Fahrenheit, Salisbury steak was 147 degrees Fahrenheit, and a Mighty Shake (nutritional supplement) was 41 degrees Fahrenheit. The mashed potatoes and peas were cold to taste. The temperatures of the foods on the tray line steam meal were measured as follows: the peas measured at 115 degrees Fahrenheit, and the cheddar mashed potatoes were 141 degrees Fahrenheit.</p> <p>On 8/5/2024 at 1:26 PM the temperature of the 3 steam table water bins on the [NAME] Unit were measured at 192 degrees Fahrenheit, 112 degrees Fahrenheit, and 168 degrees Fahrenheit (from right to left).</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/7/2024 at 12:07 PM, the Food Service Director stated nursing used the microwaves on the unit for heating food. They should have checked the food temperatures before serving them to a resident. There was a thermometer on the unit for this use. Food should be thoroughly reheated to 165 degrees Fahrenheit. No test trays had been done since the food service contractor left in November 2023. The appropriate temperatures for palatable food served was over 140 degrees Fahrenheit for hot food, and below 40 degrees Fahrenheit for cold food. 110 degrees Fahrenheit for peas and 111 degrees Fahrenheit for mashed potatoes was not appropriate. It was important for residents to get food at the proper temperatures, so it was palatable, and to prevent the spread of food borne illness. Kitchen storage areas and food service equipment should be properly maintained and cleaned for food safety and to prevent the spread of food borne illness.</p> <p>10NYCRR 415.14(d)(1)(2)</p> <p>50561</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803</p> <p>43754</p> <p>44838</p> <p>Based on observation, interview, and record review during the recertification survey conducted 8/1/2024 - 8/7/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen and in 3 of 3 nursing unit kitchenettes ([NAME], [NAME], and [NAME] Units) reviewed. Specifically, the main kitchen walk-in cooler and walk-in freezer floor were unclean and soiled with food debris; the dishwasher in the main kitchen was not working properly; the refrigerator in the [NAME] Unit kitchenette had a broken temperature gauge and was not at an appropriate temperature; the refrigerator/freezer in the [NAME] Unit pantry was unclean with food spills; and the [NAME] Unit microwave was unclean with food debris, and the sink was leaking into the cabinet below.</p> <p>Findings include:</p> <p>The facility policy, Cleanliness and Sanitation, dated 3/18/2024 documented high standards of cleanliness and sanitation would be maintained to achieve a clean, sanitary environment. Refrigerators/freezers walls, ceilings, and floors should be free of ice, stains, spots, food, drippings, and debris. Free standing refrigerators and freezers should be clean, smooth to touch, and free of dirt and debris inside and out. Microwave oven interiors would be free of debris and grease, with no grease build up.</p> <p>The facility policy, Food Safety, dated 3/18/2024 documented food safety standards were maintained for the safety of all residents. Accurate food thermometers were available and used by all food employees during storage, preparation, display, service, and transportation. Thermometers must be accurate to at least +/- 2 degrees and sanitized before use. Refrigerators must maintain foods at 41 F or below. Refrigerator and freezer thermometers must be accurate to at least +/- 2 degrees. Washing, rinsing, and sanitizing procedures must be posted and adhered to at all pot washing and dish washing stations in use.</p> <p>The following observations were made in the main kitchen with the Food Service Director present:</p> <ul style="list-style-type: none"> - on 8/1/2024 at 9:55 AM the main walk in cooler had multiple juice containers and Mighty Shake supplements directly on the floor under the shelves. The Food Service Director stated the floor should be mopped every evening and nothing should be stored on the floor. - on 8/1/2024 at 9:57 AM the walk-in freezer had 2-inch ice buildup by the door and door seal, and debris on the floor under the shelves. - on 8/1/2024 at 10:03 AM the nourishment reach in cooler contained cups of ice water with ice open to the air without lids, and a 1/4 pan on top of them. The Food Service Director stated they were cups residents would drink out of and should have lids to prevent contamination. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Katherine Luther Residential Hlth Care & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Utica Road Clinton, NY 13323	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 8/1/2024 10:12 AM the hot box had no thermometer inside, and the outside thermometer read 118 degrees Fahrenheit. The dishwasher temperature for the wash cycle was 139 degrees Fahrenheit, the rinse cycle was 133 degrees Fahrenheit, and the final rinse cycle was 133 degrees Fahrenheit. The dish washer final rinse log was not marked. The Food Service Director stated the final rinse should be checked 3 times daily.</p> <p>During an interview on 8/1/2024 at 10:23 AM, Dishwasher #37 stated dishwasher temperatures should be checked 2 times a day, once after breakfast and again after lunch. They stated they did not check the temperature that morning.</p> <p>During an interview on 8/1/2024 at 10:23 AM, the Food Service Director stated it was important to sanitize dishes to prevent the spread of infections. They expected it was checked when starting the cycle and not at the end of the cycle. The booster light was not on, and nobody told them it was not working. Improper sanitation could affect all the residents in the building. At 12:10 PM, the Food Service Director stated the booster was broken on the dishwasher. They were going to disposable dishware and switched to chemical sanitizer. They stated according to the temperature log, temperatures were up and down.</p> <p>During an observation on 8/2/2024 at 2:03 PM the [NAME] Unit kitchenette refrigerator's outside temperature gauge was not working. A probe thermometer was placed at 2:14 PM and read 54 degrees Fahrenheit. At 2:19 PM, the thermometer read 54 degrees Fahrenheit; and at 2:21 PM the thermometer read 50 degrees Fahrenheit. The temperature controlled for safety foods were discarded.</p> <p>During an interview on 8/2/2024 at 2:10 PM, Food Service Aide #33 stated they took the [NAME] Unit refrigerator temperature at 7:40 AM and documented on the paper it was 40 degrees Fahrenheit. There was a thermometer in the refrigerator.</p> <p>During an observation on 8/2/2024 at 2:27 PM the [NAME] Unit pantry refrigerator and freezer were unclean with food spills. The temperature at 2:33 PM was 48 degrees Fahrenheit, and at 2:44 PM was 43 degrees Fahrenheit. The Food Service Director stated refrigerator temperatures should be 40 degrees Fahrenheit or less. The food service aides were supposed to clean the refrigerators every shift if there were spills.</p> <p>During an observation on 8/2/2024 at 2:50 PM, the [NAME] Unit kitchenette microwave oven was unclean with food debris. The Food Service Director stated it should be cleaned every shift and when spills occurred. The freezer was not working, but there was no sign, and it was not locked. It was important to have the sign posted so people would not use the freezer. They stated the sink was leaking into the cabinet under the sink.</p> <p>During an interview on 8/6/2024 at 11:38 AM, the Food Service Director stated the dishwasher was transitioned to chemical sanitization after it was identified that it was not hitting the correct temperature on 8/1/2024. The Food Service Director and the Surveyor measured the final rinse water which did not register any sanitizer. The rinse temperature was reading 134 Fahrenheit. The Food Service Director was not sure of the machine's specifications for chemical sanitization. They stated they had been monitoring the sanitizer but had not been documenting it.</p> <p>10NYCRR 415.14(h)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838</p> <p>49448</p> <p>50561</p> <p>Based on observation, record review, and interview during the recertification survey conducted [DATE]-[DATE], the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 residents (Residents #14 and #312) reviewed and for 2 of 2 staff (Licensed Practical Nurses #1 and #2) observed. Specifically, Resident #312's and #14's urinary catheter drainage tubing was laying directly on the floor; Licensed Practical Nurse #2 provided wound care without performing appropriate hand hygiene or taking precautions to prevent contamination of the wound and clean supplies; and Licensed Practical Nurse #1 did not practice appropriate glove usage or hand hygiene during multiple resident care tasks.</p> <p>Findings include:</p> <p>The facility policy, Dressings-Dry/Clean, revised [DATE] documented scissors would be disinfected; gloves would be changed, and hands would be washed after removing soiled dressings; and gloves would be changed, and hands would be washed after cleansing the wound.</p> <p>The facility policy, Handwashing Technique, revised [DATE] documented hands would be washed before and after each procedure, between contact with different residents, and before serving food; the use of gloves did not eliminate the need for hand hygiene; and hand sanitizer would be used when contact had been made with people, equipment, or furniture.</p> <p>The facility policy Foley Catheters revised [DATE] documented the facility would assure the appropriate care of catheters and the condition of the tubing would be monitored.</p> <p>1) Resident #312 had diagnoses including acute cystitis (inflamed bladder) with hematuria (blood in urine). The [DATE] Minimum Data Set documented the resident had intact cognition, required assistance required with activities of daily living, used a wheelchair for mobility, used an indwelling urinary catheter, and had a urinary tract infection in the last 30 days.</p> <p>The [DATE] physician order documented 16 French (size of tube) 10 milliliter bulb (used to anchor the device in the bladder) drainage device, change every 42 days, and provide device care every shift.</p> <p>The Comprehensive Care Plan revised [DATE] documented the resident had a urinary drainage device. Interventions included enhanced barrier precautions, monitor for pain/discomfort due to device, and monitor for signs of a urinary tract infection.</p> <p>The following observations of Resident #66 were made:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on [DATE] at 9:29 AM sitting on the edge of their bed with the catheter tubing directly on the floor.</p> <p>- on [DATE] at 12:45 and 2:32 PM sitting in their wheelchair with their catheter tubing directly on the floor.</p> <p>- on [DATE] at 9:06 AM sitting in their wheelchair with their catheter tubing directly on the floor under their wheelchair.</p> <p>During an interview on [DATE] at 11:27 AM, Certified Nurse Aide #23 stated urinary drainage device care was provided at least once a shift and included switching bags, emptying bags, and documenting output. To prevent infections, the drainage bag should be positioned below the bladder and tubing should not be on the floor.</p> <p>During an interview on [DATE] at 11:56 AM, Certified Nurse Aide #24 stated urinary drainage device care was provided once a shift, bags should be positioned below the level of the resident's bladder in a dignity bag, and tubing and bags should not touch the floor to prevent infection.</p> <p>During an interview on [DATE] at 8:17 AM, Infection Preventionist Registered Nurse #25 stated catheter care was a yearly education and additional training was provided if a problem was identified. They expected staff to practice infection prevention as it was everyone's job to prevent infection. Catheter tubing should not be on the floor because the floor was dirty, and this contact could increase the risk of infection.</p> <p>2) Resident #66 had diagnoses including left hip Stage 3 (full thickness tissue loss) pressure ulcer. The [DATE] Minimum Data Set documented the resident had intact cognition, required assistance with bed mobility, and had one Stage 3 pressure ulcer.</p> <p>The [DATE] physician order documented cleanse left hip wound with wound cleanser, pack undermining (a passageway underneath the skin's surface) with iodoform (an antiseptic gauze that removes dead tissue) soaked with wound gel (provides moisture) and collagen powder (promotes wound healing), apply moist 2 x 2 gauze, cover with absorbent dressing then dry protectant dressing twice a day.</p> <p>During a wound care observation on [DATE] at 10:12 AM, Licensed Practical Nurse #2 entered Resident #66's room and applied gloves and a gown. They removed the soiled wound dressing, removed their gloves, did not perform hand hygiene, and applied new gloves. They cleansed the wound, retrieved a pair of scissors from the resident's dresser drawer, cut off a strip of iodoform using the scissors, soaked the iodoform strip as ordered, used their gloved fingers to directly pack iodoform into the wound, and covered the wound with a gauze moistened with normal saline (from an undated partially used bottle), They did not change their gloves or perform hand hygiene after cleansing the wound and retrieving the scissors and before applying the new dressing.</p> <p>During an interview on [DATE] at 10:25 AM, Licensed Practical Nurse #2 stated hand hygiene should be performed before and after wound care and in between changing gloves only if they touched something dirty. Multi dose bottles of normal saline should be dated when opened and open dates should be checked before using wound care products. They were unsure when the bottle of normal saline was last used or originally opened as there was no date written on it. If proper hand hygiene was not performed bacteria could be spread resulting in a wound infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 2:27 PM, Registered Nurse Manager #3 stated hand hygiene should be performed in between removing soiled gloves and applying clean gloves. Hand hygiene could be either washing with soap and water or using hand sanitizer. If clean gloves touched something dirty, they could be contaminated and should be changed before touching or applying clean wound care items. Any time a small bottle of normal saline was opened it should be dated with the date it was opened. The bottle would be good for 30 days from that open date. A bottle that was opened and not dated should not be used as it could be expired and ineffective. Not properly performing hand hygiene and using supplies with unknown expiration dates could cause treatments to be less effective or cause infection.</p> <p>During an interview on [DATE] at 8:17 AM, Infection Preventionist Registered Nurse #25 stated gloves should be worn when providing personal care, wound care, or anytime there was the potential of encountering blood or body fluids. Gloves should be changed when soiled and in between removal of a dirty dressing and application of a clean dressing. They were initially unsure if hand hygiene should be performed in between glove changes, but after referring to the policy stated anytime gloves were removed hand hygiene should be performed. Gloves did not provide a 100% barrier and hands were not clean just because gloves had been worn. The Unit Managers completed weekly hand hygiene audits and submitted to them, and no related issues had been reported. Staff received training at least annually that included hand washing, standard/contact/droplet precautions, and the use of personal protective equipment. The most recent training was one week ago.</p> <p>3) During an observation on [DATE] at 12:52 PM, Licensed Practical Nurse Assistant Manager #1 was in the dining room assisting residents with lunch wearing gloves. While wearing the same pair of gloves Licensed Practical Nurse Assistant Manager #1 provided hands on assistance to a resident attempting to sit in a chair, touched Resident #25's sandwich, provided Resident #54 hands on assistance with eating, recorded meal intakes, cleaned up dirty dishes, touched and positioned dishes with food in front of Resident #25, then removed the gloves and assisted a resident in a wheelchair to their room.</p> <p>During an interview on [DATE] at 1:53 PM, Licensed Practical Nurse #1 stated to prevent the spread of infection hand hygiene should be performed before resident care and before and after glove use. Gloves should be changed when visibly soiled, in between providing care to different residents, between going from one resident room to another, and after providing hands on assistance with feeding. Clean gloves should be applied if making direct contact with residents' food.</p> <p>During an interview on [DATE] at 8:17 AM, Infection Preventionist Registered Nurse #25 stated the same pair of gloves should not be worn to feed a resident that were previously worn to touch dirty dishes. This could result in contamination of gloves and the spread of germs from one resident to another.</p> <p>10NYCRR 415.19(b)(1)</p>		