STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335072	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Hospital - Skilled Nursing Facility	555 St Joseph's Blvd Elmira, NY 14902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on interviews and record review conducted during the Recertification Survey from 7/22/24-7/26/24, for 7 (Residents #27, #35, #36, #38, #58, #66, #76) of 14 residents reviewed, the facility did not ensure the baseline care plan (developed within 48 hours of admission and included minimum healthcare information necessary to properly care for the immediate needs of the residents, that they were able to understand) was completed within 48 hours of a resident's admission and that a summary of the baseline care plan was provided to the resident and/or their representative. Specifically, for Resident #36, #38, #58, #76, the facility could not provide documented evidence that a baseline care plan was completed within 48 hours of the resident's admission. For Residents #27, #66, and #73, the facility could not provide evidence that a summary of the baseline care plan was provided to the resident and/or their representative. The findings include, but was not limited to, the following: Review of the facility policy Baseline (48-Hour) Care Plan, dated July 2024, revealed that the baseline care plan would be developed within 48 hours of a resident's admission and include an initial set of instructions needed to provide effective and person-centered care for the resident. Additionally, the policy documented the baseline care plan would be shared with the resident and/or the residents representative. 1. Resident #28 was admitted to the facility with diagnoses that included breast cancer, history of transient ischemic attack (mini stroke), and anxiety. The Minimum Data Set Resident assessment dated [DATE], documented the resident was cognitively intact. Review of the electronic health record for Resident #28 did not include documented evidence that a baseline care plan had been completed. The facility was unable to provide any documented evidence that the resident's baseline care plan had been completed and that a summary had been provided to the resident. 2. Resident #36 was recently admitted to the facility with diagnoses including a fracture of the upper right arm, congestive heart failure, and gout. The Minimum Data Set Resident assessment dated [DATE], revealed the resident was severely cognitively impaired. Review of the electronic health record for Resident #36 did not include any documented evidence that a baseline care plan had been completed following admission to the facility. (continued on next page)

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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility was unable to provide any documented evidence that a baseline care plan had been completed for Resident #36 and a summary provided to the resident's representative. 3. Resident #27 was admitted to the facility with diagnosis including a fracture of the upper arm, dementia, and type 2 diabetes mellitus. The Minimum Data Set Resident assessment dated [DATE], revealed the resident had moderately impaired cognition. Resident #27's baseline care plan, signed by Registered Nurse Clinical Coordinator #1 on 5/7/24, did not include that a summary of the baseline care plan had been reviewed with the resident and/or their representative. During an interview on 7/25/24 at 1:35 PM, Registered Nurse Clinical Coordinator #1 stated nurse managers or the nurse admitting the resident are responsible for baseline care plans and providing a copy to the resident and/or their representative. Registered Nurse Clinical Coordinator #1 stated that they were completing the baseline care plans on an electronic health system and in that health system there is not anything that reminds the nurses to complete a baseline care plan. In an interview on 7/25/24 at 4:06 PM, the Director of Nursing stated that within 48 hours of admission the resident should have a baseline care plan started with their immediate needs and that it should be reviewed with the resident and/or the resident representative. The Director of Nursing stated the electronic health system did not make it obvious that a baseline care plan needed to be completed and that they have some newer staff that may not have gotten the training or the understanding to complete the baseline care plans. 10 NYCRR 415.11 47642

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 46526 Based on observations, interviews, and record review conducted during a Recertification Survey from 7/22/24-7/26/24, the facility did not ensure the nurse staffing information was posted with the required information and in a prominent place readily accessible to all residents and visitors. Specifically, the nurse staffing information did not consistently include the accurate number and total hours worked by licensed (Registered Nurses and Licensed Practical Nurses) and unlicensed (Certified Nurse Aides) nursing staff who were directly responsible for resident care. Additionally, the staffing information was only posted on one residential unit preventing access of the information to the residents and visitors on the second unit (a secured unit that was locked and required staff to provide elevator access to all residents or visitors). This is evidenced by the following: During observations on 7/24/24 at 12:16 PM and 4:04 PM and 7/25/24 at 1:46 PM, the facility's nurse staffing information posted did not include the actual and total hours worked for both licensed and unlicensed nursing staff. Additionally, the nurse staffing postings were located on the third-floor residential care unit, which was not accessible to residents or visitors on the fifth floor without staff assistance (badge access). Review of the daily nursing information from 6/1/24 to 7/24/24 revealed multiple days that did not include the accurate number of Registered Nurses (Registered Nurse Supervisors not included) when reviewed with the staffing schedules. During an interview on 7/24/24 at 12:30 PM, the Director of Nursing stated that the facility had 24-hour Registered Nurse Supervisor coverage in the facility at all times (7 days a week). During an interview on 7/25/24 at 8:30 AM, Scheduler #1 said they schedule staff and complete the daily nursing staffing postings. Scheduler #1 said they go over nursing staff with the Director of Nursing each morning, complete the nursing staff form for the day shift, and post it. Scheduler #1 said they would fill out the second part (evening shift staffing) around 3:15 PM, and they would complete the night shift staff the next morning (after the shift) when the posting is removed and the new day's information posted. Scheduler #1 said the purpose of the daily nursing staffing posting is to show they have adequate nursing staffing. Scheduler #1 said the daily nursing staffing is posted on the third floor (across from a nurses' station) and included the number of registered nurses, licensed practical nurses, and certified nurse aides (registered nurse supervisors not included). Scheduler #1 said they were not aware that the total number of hours worked by each discipline was required to be on the postings. Scheduler #1 said the daily nurse staffing was posted in one location in the facility (on the third-floor resident unit). If a resident (or visitor) on the fifth-floor resident unit wanted to observe it, they could ask staff who could provide a copy of the information, but that residents or visitors would not know the information was posted on the third floor if they had never been there. During an interview on 7/26/24 at 12:20 PM with the Administrator and the Director of Nursing, the Director of Nursing stated that both the number of each nursing discipline and the total hours worked by each were required to be on the daily nurse staffing posting. The Director of Nursing said they were not aware that the total hours worked was also required and were not sure why the information was only posted on one unit. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	10 NYCRR 415.13

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 45200 Based on observations and interview conducted during the Recertification Survey from 7/22/24-7/26/24, the facility did not ensure compliance with all applicable State codes. Specifically, the facility was not in compliance with section 915 of the 2015 edition of the International Fire Code as adopted by New York State, which requires the use of carbon monoxide detection in a building that has fuel-burning appliances. The findings are: Observations on 7/23/24 at 10:40 AM included a carbon monoxide detector located on the wall in the Energy Center that housed the 500-Kilowatt (kW) generator. During an interview on 7/24/24 at 2:35 PM, the Facilities Manager asked the surveyor how often the facility is supposed to test the carbon monoxide detectors. When the surveyor responded that they need to be inspected/tested monthly, the Facilities Manager stated that they are probably not doing that monthly. There was no additional documentation provided by the facility of the locations of all carbon monoxide detectors within the facility, nor was their documentation of monthly inspections and testing of carbon monoxide detectors. Observations on 7/25/24 at 12:25 PM included a natural gas range in the main kitchen and a carbon monoxide detector on the wall outside the staff dining area in the middle of the kitchen. The 2015 edition of the International Fire Code (IFC), requires carbon monoxide detection to be provided in an approved location between the fuel burning appliance and the dwelling unit, sleeping unit, or classroom; or on the ceiling of the room containing the fuel-burning appliance. Additionally, carbon monoxide alarms shall be maintained in accordance with NFPA 720. The 2012 Edition of NFPA 720, Standard for the Installation of Carbon Monoxide Detection and Warning Equipment, requires that single-station carbon monoxide alarms shall be inspected and tested in accordance with the manufacturer ' s published instructions at least monthly. 10 NYCRR: 415.29(a)(2), 711.2(a)(1); 42 CFR: 483.70(b), 2015 IFC: Section 915, 915.1, 915.1.4, Section 1103.9, 2012 NFPA 720: 8.7.1