STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335097	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
N Y S Veterans Home	4211 State Highway 220 Oxford, NY 13830

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record review, and interviews during the recertification survey conducted 5/12/2025-5/16/2025, the facility did not provide the necessary services and treatment for indwelling urinary catheter use for one (1) of three (3) residents (Resident #8) reviewed. Specifically, Resident #8 was not receiving staff assistance with changing or emptying their urinary drainage collection bag as planned. Findings include: The facility policy Indwelling Urinary Catheter Care and Management, revised 11/18/2024 documented to monitor for changes in urine output, notify the medical provider of abnormal findings, empty the drainage bag reguarly, inspect the catheter system to ensure it was a sterile continous closed system, and replace the system with a sterile no-touch technique if disconnection occurred. If patient teaching occurred documentation of indwelling catheter care and management should include teaching provided to the patient, understanding of that teaching, and follow up teaching that was needed Resident #8 had diagnoses including obstructive and reflux uropathy (urine obstruction and backflow) and urinary tract infections. The 2/24/2025 Minimum Data Set assessment documented the resident had intact cognition, had an indwelling urinary catheter, and was independent with most activities of daily living. The Comprehensive Care Plan created 3/7/2025 documented the resident required assistance to complete activities of daily living related to obstructive uropathy and the need for an indwelling urinary catheter. Interventions included urinary catheter care with morning and evening care, switch the leg drainage bag to a regular urinary drainage bag at night, and the resident required maximal assistance with the management of their indwelling urinary catheter. The following observations and interviews with Resident #8 were made: - on 5/12/2025 at 2:53 PM, they stated their indwelling urinary catheter caused discomfort and would clog up at times. Their overnight urinary drainage bag was lying in a pink basin next to the bathroom sink with 600 milliliters of dark yellow urine and the end of the connection tubing was not capped. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 5/13/2025 at 1:26 PM, lying in their reclining chair with a leg drainage bag in place on their lower left leg. Their overnight urinary drainage bag was lying in a pink basin next to the bathroom sink with 400 milliliters of yellow urine and the end of the connection tubing was not capped. They stated they did not receive any training but was able to empty their own urinary drainage bags. They switched out their overnight urinary drainage bag with a leg drainage bag in the morning, put it in the basin during the day, and emptied the urine and cleaned the overnight urinary drainage before reconnecting it at night without any staff assistance. - on 5/14/2025 at 9:26 AM, the overnight urinary drainage bag was lying in a pink basin next to the bathroom sink with 300 milliliters of cloudy yellow urine and the end of the connection tubing was not capped. - on 5/15/2025 at 9:13 AM, lying in their reclining chair with their leg drainage bag attached on their lower left leg. Their overnight urinary drainage bag was lying in a pink basin next to their bathroom sink with 200 milliliters of yellow urine and the end of the connection tubing was not capped. There was no documented evidence the resident received education for management of their indwelling urinary catheter and was able to safely and approrpriately manage their own care. During an interview on 5/16/2025 at 11:01 AM, Certified Nurse Aide #9 stated the care plan included everything regarding the resident's care including their toileting status and if they had an indwelling urinary catheter. They were familiar with Resident #8, and had cared for them that week. Resident #8 was independent with managing their indwelling urinary catheter. The resident changed out their urinary drainage bag for their leg drainage bag in the morning and emptied their leg drainage bag throughout the day. The resident would tell them how much urine they emptied so they could document it. They stated they did not monitor the resident to ensure they were managing it appropriately. The nurses were responsible for providing education to the resident and determining if the resdient could be independent with managing their indwelling urinary catheter. They were not aware the resident's care plan documented the resident required maximal assistance with their catheter management. They stated they should not have assumed the resident was independent. If the resident was not managing their indwelling urinary catheter correctly it could put them at risk for infection. During an interview on 5/16/2025 at 11:17 AM, Certified Nurse Aide #10 stated Resident #8 had an indwelling urinary catheter and could manage it independently. They did not monitor the resident performing their urinary drainage bag changes, and the resident would empty their leg drainage bag throughout the shift and let the staff know the total so they could document it. The Registered Nurse Managers provided all of the education and determined if the resident could independently manage the care for their indwelling urinary catheter. They were not aware the residents care plan documented they required maximal assistance. They stated if Resident #8 was not provided education for completing their indwelling urinary catheter care properly it could put them at risk to get an infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2025 at 12:02 PM, Registered Nurse/Charge Nurse #11 stated Resident #8's care plan documented they required maximal assistance with their indwelling urinary catheter management. Maximal assistance meant staff provided hands-on assistance with emptying the urinary drainage bags, monitoring the urine output and color, changing the urinary drainage bag over to a leg drainage bag, and providing a new urinary drainage bag and privacy bag weekly. The therapy team determined if the resident could independently manage their indwelling urinary catheter. The charge nurse or supervisor were responsible for providing the resident with education on caring for the catheter appropriately, documenting education was provided, and the resident was able to perform a return demonstration. Resident #8 should not have completed their own indwelling urinary catheter care. They stated they were not made aware the residnet was doing their own care. The resident was not educated and if they were not doing the care properly it put the resident at a higher risk for a urinary tract infection. During an interview on 5/16/2025 at 12:16 PM, Registered Nurse Supervisor #12 stated Resident #8's care plan documented they required maximal assistance with indwelling urinary catheter management which meant the certified nurse aides should empty the urinary drainage bags, ensure the bag was below the level of the bladder and in a privacy bag. If the resident was not deemed independent or did not receive education, it put them at risk for developing a urinary tract infection. There was no documentation Resident #8 was trained or could complete their indwelling urinary catheter care independently. The certified nurse aides should have followed the care plan and let the nurses know the resident wanted to complete their care independently so they could have followed up with the resident or provided training. 415.12(d)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey conducted 5/12/2025-5/16/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for one (1) of three (3) residents (Resident #33) reviewed. Specifically, Resident #33 had poor oral intake with significant weight loss and was not assessed by the registered dietitian and the facility medical providers were not made aware of the weight loss. Findings include: The facility policy Mealtime Monitor and Nourishment Monitor Records, revised 1/27/2025, documented the unit meal and nourishment intakes were recorded by the nursing staff in the electronic medical record which was used for resident clinical assessments. The clinical nutrition staff were to be notified of residents who were eating poorly for several days or not taking nourishments well. The facility policy Nutrition/Nursing-Weight Change, revised 1/28/2025, documented nursing staff were responsible for obtaining a monthly weight for each resident and the charge nurse would review the weights and request reweights as necessary. Dietary reviewed the weights and evaluated if the resident had experienced any undesirable weight losses or gains during the past month and six-month period. If the weight change was not planned change, the physician would be notified. The clinical nutrition staff would review significant weight changes and work with the treatment team to develop a plan to identify the problem and formulate goals and interventions regarding the change. The facility policy Full Nutritional Assessments/Quarterly Notes/Nutrition Risk Notes/Care Plans/Revision of Nutritional Needs, revised 05/02/2025, documented residents at increased nutrition risk were reviewed monthly at a minimum. Risk notes were recorded in the interdisciplinary portion of the resident's medical record by the nutrition practitioner. A revised estimation of nutritional needs may have been required between full assessments or quarterly notes based on significant weight changes, changes in skin integrity, laboratory values, or with diagnosis that affected nutritional needs. Resident #33 had diagnoses including Alzheimer's disease and chronic obstructive pulmonary disease (lung disease). The 3/10/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, had wandering behaviors that occurred daily, was independent with eating, had no swallowing conditions, and had a significant weight loss while not on a physician-prescribed weight loss regimen. The 7/22/2024 Comprehensive Care Plan documented: - the resident required assistance with their activities of daily living due to the diagnosis of Alzheimer's dementia with impaired cognition. Interventions included the resident was independent with eating with set up assistance as needed and required a non-skid placemat. - revised 3/11/2025, the resident was at risk for alterations in nutritional status/needs, oral intakes, and appetite. The resident seldomly attended breakfast, was at risk for weight loss, preferred small portions, and had a 17-pound decline or 10.6% weight loss in six months on 3/11/2025. Interventions included a regular diet with thin liquids; provide fluid and snack of choice in the morning and before bed; provide Boost Breeze (a nutrition supplement) juice twice a day; and monitor weight and intakes via the electronic medical record, direct care staff report, and random meal rounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's weight record documented: - on 12/5/2025 158.4 pounds; - on 1/8/2025 148.8 pounds (6% weight loss in 1 month) with no documented reweight. - on 2/12/2025 150 pounds, The 3/11/2025 Registered Dietitian #2 quarterly progress documented the resident was on a regular diet with thin liquids. They received small portions and their intakes were poor. Their lunch and supper meals averaged about 38% consumption and the resident skipped breakfast routinely. The resident had a significant weight loss of 17-pounds or 10.6% in 6 months and was down 4.5% or 6.8 pounds in one month. The resident's snacks in the evening and at bedtime had fair acceptance while morning and late-night snack acceptance was poor. The resident had moderate malnutrition was a high nutritional risk. The plan was to trial Boost Breeze juice twice a day between meals at the evening and bedtime snack times. The 3/12/2025 weight record documented the resident weighed 142.6 pounds (4.9% decrease in 1 month) with no documented reweight. The 4/7/2025 Nurse Practitioner #3 progress note documented the resident's intakes were at baseline, their weight was stable, and they had no acute illnesses. The 5/2/2025 Physician #4 progress note documented the resident had chronic abdominal discomfort and was a poor historian due to dementia. There was no documentation of the resident's intakes or weight loss. There was no documented evidence the medical providers were made aware of the resident's weight loss. The 5/7/2025 weight record documented the resident weighed 132.2 pounds, a loss of 7.29 % in one month and a 16.54 % Loss in 6 months. There was no documented evidence of a nutritional assessment and plan after the resident's significant weight loss on 5/7/2025. The resident's meal intake record for 5/2025 documented did not occur for: - breakfast meals on 5/1/2025 to 5/12/2025 and on 5/14/2025. - lunch meals on 5/1/2025 to 5/8/2025, 5/10/2025 to 5/12/2025, and on 5/14/2025. - dinner meal on 5/2/2025 and 5/9/2025. The resident's meal intake record for 5/2025 documented intakes of 50% or less for the following meals: - breakfast meal on 5/13/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- lunch meals on 5/9/2025 and 5/13/2025. - dinner meals on 5/3/2025, 5/5/2025 to 5/7/2025, and 5/10/25 to 5/14/2025. The resident's snack intake record for 5/2025 documented did not occur for: - evening shift snacks on 5/1/2024 to 5/2/2025, 5/9/2025 to 5/11/2025, and 5/14/2025. - night shift snacks from 5/1/2025 to 5/11/2025 and 5/13/2025. - day shift snack 2 on 5/1/2025 to 5/2/2025, 5/4/2025, 5/6/2025 to 5/8/2025, and 5/10/2025 to 5/14/2025. - evening shift snack 3 on 5/7/2025 and 5/10/2025. The resident was observed on: - 5/12/2025 at 1:00 PM, curled up in bed with a blanket pulled over their head. They did not come out to the dining room for lunch and there was no lunch tray in the room. - 5/14/2025 at 11:41 AM, lying on their bed facing the door. At 12:28 PM, they were asleep facing the door with their blanket pulled up to their nose. At 12:48 PM, the dining staff were cleaning up the lunch meal, no tray had left the dining room for the resident. At 12:49 PM, the resident was asleep on their bed with no meal tray or alternative meal in their room. During an interview on 5/16/2025 at 10:27 AM, Certified Nurse Aide #5 stated if a resident refused a meal, it was documented as did not occur and they should report it to the nurse. Resident #33 often refused meals but got snacks in-between. The resident was not big on the breakfast meal. They stated it was not concerning for the majority of Resident #33's breakfast and lunch meals to be documented as did not occur for 5/2025 as the resident was not usually up for breakfast and sometimes it was not worth the fight to get the resident to come out to the dining room for lunch. The resident was more of an evening person and staff would give the resident a snack. Weight changes that were plus or minus 5 pounds from the previous weight were reported to the nurse. During an interview on 5/16/2025 at 10:51 AM, Licensed Practical Nurse #6 stated the percentage of meals eaten by residents were documented by the certified nurse aides who tracked the meals on paper and input them into the electronic medical record. If a resident refused a meal, they were notified by the certified nurse aide. If a resident refused both breakfast and lunch, they should notify the charge nurse or the nursing supervisor. They should also write a progress note and pass it along to the next shift. The certified nurse aides reported to the nurse if there were changes in a resident's weight and they would pass the information on to a supervisor. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2025 at 10:56 AM, Registered Nurse Charge #7 stated Resident #33 was mostly up in the afternoon and night eating. They were aware Resident #33 was refusing most of their breakfast, lunch and most of their morning and afternoon snacks. They were unaware the resident's intakes for their supper meals was minimal if they ate at all as it had not been reported to them. They would have notified he medical providers if they had known. The registered dietitian kept track of a resident's weights and received an email if there was a weight change. It was concerning Resident #33 had lost 10 pounds in a month and had been refusing meals. Nutrition had a list of malnourished residents they kept track of. They stated they had not received any emails or notifications regarding Resident #33. Resident #33's health could decline further if they consistently refused meals, had poor intake, and was losing weight. During an interview on 5/16/2025 at 11:15 AM, Registered Dietetic Technician #8 stated they and the registered dietitians followed the residents' weights. If a resident was identified as high risk, they were assessed and followed by the registered dietitians. The residents identified as high risk were followed monthly at a minimum, but it also depended on the resident's needs. If a resident was consistently refusing breakfast, lunch, their morning snack, afternoon snack, they expected to be notified. They checked resident weights weekly at a minimum. Registered Dietitian #2 followed Resident #33. If a resident had a significant weight loss, they would assess the resident, write a report, and then discuss the situation with the medical providers. During an interview on 5/16/2025 at 11:42 AM, Nurse Practitioner #3 stated they were unaware Resident #33 was refusing breakfast, lunch, their snacks, and had poor intakes. The consistent refusals of meals were something they should be notified of. They were unaware the resident had lost 10 pounds in one month or had significant weight loss over six months and they should have been notified. If Resident #33 continued refusing meals, having poor intakes, and losing weight, they could become dehydrated, their lab values could be off and overtime the resident could decline further. They expected a resident identified as a malnutrition risk be followed closely by the registered dietitian. During an interview on 5/16/2025 at 1:07 PM, Physician #4 stated they were made aware when a resident had significant weight loss or was identified as a malnutrition risk. For their 60-day federally mandated visits they reviewed the resident's chart which included the resident's weight. When a resident lost weight, they were usually contacted the same day. If a resident triggered for significant weight loss in six months and was identified as a high risk, they expected to be notified. They stated with Resident #33's dementia they were expected to lose weight as the disease progressed but they still expected to be notified of weight loss so the resident could be assessed. They were unaware of the resident's recent weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/16/2025 at 2:03 PM, Registered Dietitian #2 stated they should notify the medical providers if a resident had a significant weight loss over six months. The protocol for residents who were on weekly weights was to check the weight every week, but they checked the weights every day. If a resident was weighed on 5/7/2025 they likely looked at the weight on 5/8/2025 or 5/10/2025. They were unsure if they were aware of Resident #33's recent significant weight loss. It had been a while since they assessed Resident #33 as they were only doing the assessments required for the Minimum Data Set which were quarterly. If a resident lost over 5% in a month, they should assess the resident, consider new interventions, and place the resident on the high-risk list. They had not kept up the high-risk list due to being short staffed. They stated currently they were mainly doing quarterly assessments and assessments on the new admissions. They were unaware Resident #33 was not eating their breakfast, lunch, daytime snacks, and their supper intake was variable. They would have alerted the medical providers and tried new interventions. If Resident #33 was not eating and their weight continued to decline the resident's overall health could decline. 10NYCRR415.12(i)(1)