STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335216	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avon Nursing Home L L C	215 Clinton Street Avon, NY 14414

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey from 09/26/2024 to 10/02/2024, the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer a medication for one (Resident #7) of six residents reviewed. Specifically, Resident #7 was observed with a prescribed inhaler kept at the beside with no documented evidence that an assessment had been completed to determine their ability to safely self-administer the medication or a physician's order for self-administration. This was evidenced by the following: Review of the facility policy Administering Medications, dated April 2019, revealed that medications are administered in accordance with prescribed orders. Residents may self-administer their own medications if the attending physician, in conjunction with the interdisciplinary care team, has determined the resident to have the decision-making capacity to do so. The facility education reference guide Self-Administration of Medications, reviewed September 2023, documented that nursing will obtain an order from the Medical Provider for which medications are approved for self-administering. Resident #7 had diagnoses that included Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs that is characterized by breathlessness and cough), schizophrenia, and pneumonia. The Minimum Data Set Resident Assessment, dated 07/24/2024, documented the resident had moderately impaired cognition. During observations on 09/30/2024 at 9:08 AM, Resident #7 had an Anoro Ellipta inhaler in a plastic bin on their bedside table. During an interview at this time, Resident #7 stated they have had their inhaler a long time and that they kept their inhaler in the plastic bin on the bedside table and used it every day. Resident #7's Comprehensive Care Plan, revised 08/01/2024, did not include any information related to Resident #7 having been assessed for safe administration of inhalers. Resident #7 Physician's orders, dated 09/09/2024, included an Anoro Ellipta inhaler (used to prevent air flow obstruction in the lungs) one puff daily at 9:00 AM with special instructions to rinse the mouth after use. The orders did not include that resident could self-administer the inhaler or leave the inhaler at the bedside. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/30/2024 at 10:41 AM, Registered Nurse #1 stated in order for a resident to self-administer a medication an order (Physician) should be in the electronic medical record. Registered Nurse #1 said that they had talked to the acting Director of Nursing and the inhaler for Resident #7 was removed from Resident #7's room until an order could be obtained from the physician. During an interview on 09/30/2024 at 11:17 AM, the Registered Nurse Manager/Acting Director of Nursing stated that a resident should be evaluated by the physician for self-administration of a medication and there should be a note in the medication order for the Resident to keep the medication at their bedside and self-administer it. The Registered Nurse Manager/Acting Director of Nursing said that Resident #7 should not have had the inhaler in their room. During an interview on 10/02/2024 at 9:35 AM, the Registered Nurse Manager/Acting Director of Nursing stated that they had no knowledge that Resident #7 kept an inhaler at their bedside and should not have been. The Registered Nurse Manager/Acting Director of Nursing said that there should be an assessment and education provided by nursing for a resident to self-administer a medication. 10 NYCRR 415.3

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on observation, interviews, and record review conducted during the Recertification Survey from 09/26/2024 to 10/02/2024, the facility did not develop and implement a comprehensive plan of care (including measurable goals and interventions) for one (Resident #14) of two residents reviewed for communication and sensory. Specifically, Resident #14's Comprehensive Care Plan did not include that the resident had profound hearing loss, used of an amplifier (hearing aid), or was able to read lips. This is evidenced by the following: The facility policy Resident-Centered Care Planning last reviewed February 2024, documented each resident will have a Comprehensive Resident-Centered Care Plan that is consistent with resident rights and person-centered care. Resident #14 had diagnoses that included a stroke, right sided hemiplegia and hemiparesis (weakness and/or paralysis on one side of the body), and hearing loss. The Minimum Data Set Resident Assessment, dated 09/20/2024, documented that Resident #14 was cognitively intact, had moderate difficulty with hearing (speaker has to increase volume and speak distinctly), and requires the use of hearing aids or other hearing appliances. Review of the current Comprehensive Car Plan revealed no information related to Resident #14's hearing loss, use of an amplifier, or any other interventions (such as lip reading) to assist the resident with communication needs. The Care Area Assessment included that Resident #14 triggered for hearing loss and that communication should be care planned for. During an interview on 09/26/2024 at 12:24 PM, Resident #14 stated they lost 80% of their hearing years ago and have used a left ear amplifier for more than [AGE] years. Resident #14 said that currently all employees were wearing masks and that they would prefer they wore clear masks so they could lip read. During an observation on 09/26/2024 at 12:30 PM, Certified Nursing Assistant #3 was in the resident's room wearing a surgical face mask. Resident #14 asked if Certified Nursing Assistant #3 was speaking to them and that they were unable to hear or read lips with the mask on their face. During an observation on 09/30/2024 at 10:02 AM, Resident #14 was in the therapy room working with Physical Therapy. Physical Therapist #1 was wearing a surgical face mask. During an interview on 10/01/2024 at 9:20 AM, Registered Nurse Manager/Acting Director of Nursing stated that hearing loss and use of an amplifier were not included in Resident #14 Comprehensive Care Plan. During an interview on 10/01/2024 at 9:50 AM, Certified Nursing Assistant #1 stated that Resident #14 had difficulty hearing them if they wore a surgical mask, and in order to communicate with the resident, they need to pull down their mask for Resident #14 to see their lips so they can read their lips in order to participate and communicate with them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/2024 at 11:54 AM, Social Worder #1 stated that Resident #14 Comprehensive Care Plan did not include a plan for hearing loss or the need for the hearing amplifier and that the care plans should be more specific and tailored for individual resident care. 10 NYCRR 415.11(c)(1)

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46526 Based on observations, interviews, and record reviews conducted during the Recertification Survey from 09/26/2024 to 10/02/2024, the facility failed to ensure services were provided to maintain acceptable parameters of nutritional status for one (Resident #27) of two residents reviewed for nutrition. Specifically, Resident #27 had multiple meal refusals and decreased intakes (less than 50%) for approximately two months resulting in a 31 pound (14.4%) unplanned, severe weight loss. The facility could not provide evidence that nursing leadership, dietary or the medical team had been notified or any supplemental interventions had been implemented. This resulted in actual harm to Resident #27 that was not Immediate Jeopardy and is evidenced by the following: The facility policy Nutritional (Impaired)/Unplanned Weight Loss - Clinical Protocol, dated September 2017, included nursing staff would monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. Additionally, staff would report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. Resident #27 had diagnoses including a recent stroke (07/16/2024), depression, and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 07/21/2024, revealed Resident #27 was cognitively intact and required setup assistance with eating. Review of Resident #27's Comprehensive Care Plan, dated 08/01/2024, revealed the resident was at risk for suboptimal nutrition and dehydration. Interventions included to provide the diet as ordered, supplements and snacks as needed or requested, and to monitor the resident's meal intakes and weights. During an observation on 09/26/2024 at 12:45 PM, a facility staff member entered Resident #27's room with a lunch tray and exited the room less than 60 seconds later with the untouched lunch tray. During an observation on 09/30/2024 at 12:50 PM, Resident #27 was lying in bed with their eyes closed. There was no lunch tray in the resident's room, and the lunch meal ticket, located on the nurses' desk counter, had refused handwritten on it. In the most recent dietary progress note, dated 07/27/2024, Registered Dietician #1 documented Resident #27's current weight was 206 pounds, down from 212 pounds a month ago, food intake averaged 76%-100%, and there were no nutritional issues at the time. Physician orders, dated 08/09/2024, documented a regular diet with consistency as tolerated. There were no further orders for nutritional supplements or any other interventions to prevent weight loss. Review of the Vitals Report forms used by staff for documentation of meal intakes from 08/07/2024 to 08/31/2024 revealed multiple meals not documented at all, and multiple meals documented with intakes of less than 50%, less than 26%, none (zero % of the meals consumed), or that the meal was refused. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the Vitals Report form of meals intakes from 09/01/2024 to 10/01/2024 revealed for 92 meal opportunities staff had documented the following: - Refused - 26 meals - None (0% meal consumed) - 20 meals - 1-25% - 17 meals - 26% -50% - 10 meals - Resident unavailable or no documentation at all - 8 meals Review of Resident #27's documented weights revealed on: - 07/03/2024 was 213 pounds - 7/16/2024 was 206 pounds - 08/06/2024 was 206 pounds - 09/03/2024 was 201 pounds Review of interdisciplinary team progress notes, dated 09/01/2024 to 09/29/2024, revealed nursing staff had documented on multiple occasions Resident #27 had refused a meal. There was no documented evidence nursing leadership, the dietician, or the medical team had been notified of the decreased intakes or the refusals. In a nursing progress note, dated 09/30/2024, the Acting Director of Nursing documented Physician #1 saw Resident #27 for their routine medical visit and was made aware the resident was not eating or drinking well. There were no new orders at that time. In a medical Visit Note, dated 09/30/2024, Physician #1 documented Resident #27 had a progressive decline with decreased oral intake and weight loss and the plan was to continue with current treatment. Review of Resident #27's electronic medical record revealed no documented evidence that the medical team had discussed any weight loss plans with the resident or their representative. During an interview on 10/01/2024 at 11:20 AM, Certified Nursing Assistant #2 said if a resident refused a meal, they would talk to the resident to try to identify the reason, offer alternatives, and notify the nurse. Certified Nursing Assistant #2 stated Resident #27 had been refusing most of their breakfast that week. During an interview on 10/01/2024 at 11:27 AM, Resident #27 said they did not eat breakfast that day and did not have an appetite. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an observation on 10/01/2024 at 12:49 PM, Resident #27's lunch ticket was observed on the nurses' desk counter with refused handwritten on it. During an interview on 10/01/2024 at 1:30 PM, Licensed Practical Nurse #1 said the Certified Nursing Assistants documented how much a resident eats and drinks and they would expect to be made aware if a resident refused a meal or had a low meal intake. Licensed Practical Nurse #1 said this information should be passed from nurse to nurse during report, and if a resident was refusing meals or having decreased intakes, it should be documented and reported to the nurse manager. Licensed Practical Nurse #1 said Resident #27 had a stroke not too long ago and they knew that a week or two ago, Resident #27 had been refusing quite a bit, mostly lunch, but they had not been told during morning report of any changes (meal refusals or decreased intakes) for Resident #27. During an interview on 10/01/2024 at 1:43 PM, the Acting Director of Nursing said the Certified Nursing Assistants should look at residents' meal trays and enter the intakes (amount consumed) into the electronic medical record for all meals. The Acting Director of Nursing stated if a resident refused a meal or had decreased intake, staff should encourage the resident, and notify the nurse who should check on the resident and try to find a reason why (refused a meal or decreased intake). The Acting Director of Nursing said the nurse should notify either nursing leadership or the medical provider if a resident had consumed less than 25% of one meal and refused the other two meals in one day. The Acting Director of Nursing stated Resident #27 had a stroke a few months prior with a change in personality and poor appetite and had been started on an antidepressant. The Acting Director of Nursing stated Resident #27 had not been eating for the past week or so, and the resident's representative was aware and said the resident would do what they wanted. During an immediate review of the documented meal intakes for Resident #27, the Acting Director of Nursing stated they were not aware of the extent that Resident #27 had been refusing meals. The Acting Director of Nursing stated they told Physician #1, who saw Resident #27 on 09/30/2024, but Physician #1 did not order any new interventions for Resident #27's nutrition status after the visit. The Acting Director of Nursing said residents' weights are done monthly unless otherwise ordered and was not aware if the resident had been weighed yet this month. On 10/02/2024 at 2:36 PM, a weight was obtained for Resident #27 that was 182 pounds or a 9.2% weight loss in one month and 14.5% over three months. During a telephone interview on 10/01/2024 at 3:40 PM, Registered Dietician #1 said they follow-up with residents' monthly weights and receive emails from the Acting Director of Nursing and Social Worker #1 to keep them in the know. Registered Dietician #1 stated they should be notified of a resident's meal refusals or decreased intakes, but this would depend on the resident (no standard number of refusals or intake values). Registered Dietician #1 said they usually reviewed residents' monthly weights around the 10th of the month, and they had not received any emails from the Acting Director of Nursing related to any issues with Resident #27. Registered Dietician #1 stated this was an unusual situation and they would definitely follow up with the resident and the Medical Director. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 10/01/2024 at 4:17 PM, Physician #1 said their understanding was that residents' intake amounts were monitored at each meal and if there was a concern about weight loss or diminished oral intake, it would be escalated to a higher level of administration. Physician #1 said if a resident was frequently refusing meals, staff should notify (nursing) leadership, and if nursing leadership felt they had a concern they should notify the medical provider. Physician #1 said during their visit with Resident #27 the previous day, it was mentioned the resident had poor oral intakes and any information regarding this visit could be found in the resident's progress notes. 10 NYCRR 415.12(i)(1)