| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335219 | A. Building<br>B. Wing | 02/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Newark Manor Nursing Home Inc | 222 West Pearl Street<br>Newark, NY 14513 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>46880<br><br>Based on observations and interview conducted during the Recertification Survey from 02/24/2025 to 02/28/2025 for three (North, West, and South) of three resident units, the facility did not provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. Specifically, exhaust ventilation in required areas was not functional. The findings are:<br><br>Observations on 02/24/2025 at 10:05 AM included a significant foul odor inside the North Hall soiled utility room and the exhaust ventilation grate in the ceiling was observed to not be drawing air out of the room when a piece of paper was placed against the grate.<br><br>Observations on 02/24/2025 from 10:11 AM included the exhaust ventilation grate in the ceiling of the shared bathroom for resident rooms W-27 and W-25 was observed to not be drawing air out of the room when a piece of paper was placed against the grate.<br><br>Observations on 02/24/2025 at 10:15 AM included the exhaust ventilation in the [NAME] Hall soiled utility room was not functional when a wall switch was pressed for a ceiling fan. During an interview at this time, the Director of Environmental Services stated that they think the motor on the roof is bad and that there is only one unit for the exhaust in the entire building.<br><br>Observations on 02/24/2025 from 10:38 AM included the exhaust ventilation grate in the ceiling of the shared bathrooms for resident rooms S-6, S-7, S-8, and S-9 were observed to not be drawing air out of the rooms when a piece of paper was placed against the grates.<br><br>10NYCRR: 415.29, 415.29(h)(1,2), 415.29(j)(1),<br><br>10NYCRR: 713-1.9(d) |

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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49368<br><br>Based on observations, interviews, and record review conducted during the Recertification Survey from 02/24/2025 to 02/28/2025, for 1 (Resident #44) of 15 resident care plans reviewed, the facility did not review and revise the resident's care plan as necessary to meet the resident's current needs. Specifically, Resident #44 had history of skin tears in addition to a current skin tear on their forearm. Their person-centered care plan was not revised to include the resident was at risk for skin tears or that they had a current skin tear or interventions to prevent ongoing skin tears. This is evidenced by the following:<br><br>Resident #44 had diagnoses including dementia, failure to thrive, and depression. The Minimum Data Set Resident assessment dated [DATE], documented the resident was severely impaired of cognitive function.<br><br>The Comprehensive Care Plan initiated on 12/27/2024, included Resident #44 had the potential for pressure ulcer development. The Care Plan did not include that the resident was at risk for skin tears related to frail skin or interventions to prevent further skin tears.<br><br>Review of a nursing progress note documented by the Director of Nursing on 06/24/2024, revealed Resident #44 sustained a skin tear on their left forearm during a transfer using a non-mechanical lift.<br><br>Review of a nursing progress note documented by Licensed Practical Nurse #4 on 10/09/2024, revealed Resident #44 had a skin tear on the top of their left-hand found during morning care possible being related to bumping their hand on the side rail of their bed.<br><br>Review of a nursing progress note documented by Licensed Practical Nurse #3 on 02/10/2025 revealed Resident #44 had a half dollar sized skin tear to the right forearm.<br><br>The current physician orders dated 02/11/2025 documented to cleanse right forearm skin tear with normal saline, pat dry, apply triple antibiotic ointment, and cover with dry dressing daily until healed.<br><br>In a nursing progress note dated 02/17/2025 Licensed Practical Nurse #4 documented Resident #44 somtimes bumped their arms on the table while attempting to eat and was sometimes non-compliant and attempted to get out of bed unassisted.<br><br>During observations on 02/24/2025 at 3:19 PM, 02/26/2025 at 9:36 AM and 02/26/2025 at 11:54 AM, Resident #44 had both forearms exposed with no arm protection to prevent skin tears.<br><br>During an interview on 02/27/2025 at 9:59 AM, Certified Nursing Assistant #1 stated they know what care a resident needed by looking at the resident's care plan, and the care plan should tell them everything about the resident to provide the proper care to them.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 02/28/2025 at 12:59 PM, the Assistant Director of Nursing, stated they would know when a resident was at a higher risk for impaired skin integrity by reading their care plan including current skin impairment. The Assistant Director of Nursing stated when a resident was at risk, it should be in the resident's care plan. The Assistant Director of Nursing stated that Resident #44 did have a current skin tear, and they believed the nurse managers were updating residents care plans, but the Director of Nursing and the Assistant Director of Nursing could also update them. They stated it was important to include the risk for altered skin integrity in the resident's care plan so everyone can be aware, and that Resident #44 should have a care plan for the actual skin tears and being at risk for them.<br><br>10 NYCRR 415.11(c)(2)(iii) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49368<br><br>Based on observations, interviews, and record review conducted during the Recertification Survey from 02/24/2025 to 02/28/2025, for one (Resident #18) of one resident reviewed, the facility did not provide appropriate treatment and services to prevent potential complications for a resident who was receiving nutrition via a feeding tube (a tube inserted directly into the stomach via the abdomen to administer nutritional supplements). Specifically, Resident #18's tube feeding was not appropriately monitored to ensure the amount infused daily was the amount ordered by the physician. Additionally, the resident had multiple documented entries in the electronic medical record of tube feeding residuals (amount of feeding tube liquid not absorbed/not tolerated creating a potential hazard) that were greater than 400 milliliters and the facility was unable to provide documented evidence that the physician had been notified or that the residuals were held and rechecked after two hours as ordered by the physician to ensure the necessary nutrition and prevent complications. This is evidenced by the following:<br><br>Review of the facility policy Enteral Nutrition dated July 2012 revealed that enteral (via a feeding tube) feeding orders will be written to ensure consistent volume infusion. The following information will be included to ensure that the full volume will be infused via pump feedings, regardless of any interruption of feeding, product name, type of tube, rate of infusion (number of milliliters per hour), total calories per day, start time, and total daily volume to be infused (number of milliliters per day).<br><br>Resident #18 had diagnoses including dysphagia (difficulty swallowing), failure to thrive, and chronic obstructive pulmonary disease. The Minimum Data Set Resident assessment dated [DATE], documented the resident was moderately impaired of cognitive function, had no behaviors, received 51 percent or more of their total calories, and 501 milliliters or more of their fluid needs per day through a feeding tube.<br><br>The current physician orders dated 12/23/2025 included the resident was to have nothing by mouth and had a feeding tube with feedings to include:<br><br>a. Continuous Fibersource High Nitrogen tube feeding at 75 milliliters per hour for 24 hours for a total volume of 1,800 milliliters, staff to document amount each shift of 600 milliliters.<br><br>b. Check and record residual amounts every shift, contact the physician if residuals are greater than 400 milliliters. Recheck residuals again after two hours and if below 400 milliliters may restart feeding.<br><br>Resident 18's Comprehensive Care Plan dated 01/06/2025 documented the resident was a potential risk for sub-optimal nutrition and dehydration due to having a feeding tube. Interventions included the resident was to ingest nothing by mouth, was on aspiration precautions (steps taken by the facility to prevent complications such as inhalation of liquids into the respiratory tract), received tube feedings (liquid nutrition) at 75 milliliters per hour for 24 hours, 100 milliliters of water every six hours and 50 milliliters of water three times per day with medications. Staff are to monitor weights and intakes as available and monitor for signs and symptoms of dehydration.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Medication Administrator Record dated 02/01/2025 through 02/27/2025 revealed the daily amount of Fibersource High Nitrogen administered to the resident ranged from to 1275 milliliters to 3190 milliliters per day (versus the ordered 1800 milliliters). Residual amounts of the tube feedings were documented as 700 milliliters up to 902 milliliters on three occasions.<br><br>There was no documented evidence that the Physician had been notified of residual tube feeding amounts greater than 400 milliliters or that the tube feeding was held, and residuals rechecked after two hours per the physician's orders.<br><br>In a nutrition/dietary progress note dated 02/23/2025 the Registered Dietitian documented Resident #18 tolerated the tube feeding formula and rate well, that the resident had a weight loss over the past six months and the tube feeding amount was increased.<br><br>During observations on 02/24/2025 at 10:22 AM, 02/26/2025 at 9:15 AM and 02/27/2025 at 10:15 AM, Resident #18 was receiving continuous tube feeding via a tube feeding pump set at 75 milliliters per hour. The tube feeding ready to hang formula bag was labeled with resident's name, date, and rate but did not include a start time (when a new tube feeding bag was started).<br><br>During an interview on 02/27/2025 at 11:49 AM and again at 1:51 PM Licensed Practical Nurse Manager #1 stated the residents tube feeding order stated 600 milliliters each shift and the nurses documented the totals in the medication administration record. They should clear out the total (amount infused) on the machine each shift so it starts for the next shift and the nurse should look (at the amount infused) prior clearing it out. The total documented per 24-hours should be 1800 milliliters. Licensed Practical Nurse Manager #1 stated if the nurse was documenting less than 600 milliliters per shift it was most likely the tube feeding was held (for some reason). Licensed Practical Nurse Manager #1 stated that Resident #18's tube feeding runs for 24 hours, and it was hard to know when a bag was started, emptied and another one hung but the predetermined amount per shift of 600 milliliters should be documented in the medication administration record. Licensed Practical Nurse Manager #1 said they do not monitor the tube feeding intakes because the Registered Dietitian does.<br><br>During a telephone interview on 02/27/2025 at 12:52 PM the Registered Dietitian stated that Resident #18 should receive 600 milliliters of tube feeding per shift and the nurses should document (the amounts) in the medication administration record. The Registered Dietitian stated they do not double check what the nurses documented but if the resident was losing weight they should then check if the nurses were documenting correctly and if there were any residuals documented. The Registered Dietitian stated they did not know how to review the resident's electronic medication administration record to review the documented tube feedings amount but nursing should. The Registered Dietitian stated the resident had a history of unplugging their tube feeding.<br><br>During an interview on 02/28/2025 at 11:26 AM, Registered Nurse #1 stated that Resident #18 has been known to play with the tube feeding ports and fiddle with the tube feeding pump and has turned the feeding tube pump off.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 02/28/2025 at 1:36 PM, the Director of Nursing stated nurses should notify the physician if there were any tube feeding residuals greater than 400 milliliters and then recheck the residuals. The Director of Nursing said the nurse managers, charge nurses and the Registered Dietitian should be monitoring the resident's total tube feeding and fluid intakes (to ensure ordered amounts were being given on a daily basis). The Director of Nursing said they knew Resident #18 had recently lost weight and their tube feeding rate had been increased.<br><br>During a telephone interview on 02/28/2025 at 2:05 PM, the Medical Director stated they should be notified if Resident #18 had residuals greater than 400 milliliters since there was an order in place. The Medical Director said the Registered Dietitian should be monitoring the residents tube feeding since the providers are changing the orders based on their recommendations and both nursing and the Registered Dietitian should be monitoring the resident's total fluid intakes daily and any residuals.<br><br>10 NYCRR 415.12(g)(2) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49368<br><br>Based on observations, interviews, and record review conducted during the Recertification Survey from 02/24/2025 to 02/28/2025, for two (Resident #9 and #12) of seven residents reviewed, the facility did not ensure a medication error rate of five percent or less. There were 2 medication errors for 30 opportunities resulting in a medication error rate of 6.67 percent. Specifically, during observations of medication administration, Resident #9 did not receive the correct dose of one medication and Resident #12 did not receive one medication in the correct form as prescribed by the physician. This is evidenced by the following:<br><br>The facility policy Administering Medications revised April 2019 documented medications are administered in accordance with prescriber orders and the individual administering the medication should check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>1. Resident #9 had diagnoses that included constipation, heart failure, and anxiety. The Minimum Data Set Resident assessment dated [DATE] documented Resident #9 was cognitively intact.<br><br>The active physician orders reviewed on 02/27/2025 included an order for bisacodyl (stool softner) 10 milligrams two times daily for constipation.<br><br>During an observation on 02/27/2025 at 9:17 AM Licensed Practical Nurse #1 administered 5 milligrams (one tablet) of bisacodyl. In a follow up interview at 10:15 AM, Licensed Practical Nurse #1 stated the physician had ordered a total of 10 milligrams of bisacodyl and Resident #9 should have received two bisacodyl tablets as opposed to one but that they did not realize they needed to give two tablets.<br><br>2. Resident #12 had diagnoses that included a stroke, high blood pressure, and depression. The Minimum Data Set Resident Assessments dated 01/10/2025 documented Resident #12 had severe impairment of cognitive function.<br><br>The active physician orders reviewed on 02/26/2025 included an order for simethicone (relieves bloating and gas) oral tablet 80 milligrams three times daily and as needed every six hours for indigestion.<br><br>During an observation on 02/26/2025 at 4:15 PM, Licensed Practical Nurse #2 removed one simethicone 80 milligrams chewable tablet from the bottle, placed it in a cup with five other medications and administered the entire cup of medications. Resident #12 swallowed all medications without chewing any of the tablets.<br><br>During an observation and interview on 02/27/2025 at 3:40 PM Licensed Practical Nurse #2 stated simethicone was a medication stocked by the facility. Review of the stock bottle at this time revealed the simethicone was a chewable tablet. Licensed Practical Nurse #2 stated that if the medication was a chewable (tablet) it should be put it in a separate cup from the swallowable medications and administered separately. Licensed Practical Nurse #2 said they did not realize the simethicone that was administered was a chewable tablet (versus one you can swallow whole).<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 02/28/2025 at 1:18 PM the Assistant Director of Nursing stated medications should always be given per the physician order and if there is an issue or concern with an order the nurses should clarify it with the medical provider. The Assistant Director of Nursing stated if the physician order does not state chewable, and the medication on hand is chewable the order should be clarified with medical prior to administration.<br><br>10 NYCRR 415.12(m)(1) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>49368<br><br>Based on observations and interviews conducted during a Recertification Survey from 02/24/2025 to 02/28/2025, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws for one (North Unit) of two medication storage rooms reviewed. Specifically, multiple bottles of expired medications were found in the North Unit medication storage room. This is evidenced by the following:<br><br>The facility policy Medication Labeling and Storage dated January 2023, included if the facility had discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy was contacted for instructions regarding returning or destroying those items.<br><br>During an observation on 02/26/2025 at 2:25 PM, the North Unit medication storage room included the following expired medications:<br><br>a. One bottle of magnesium oxide 400 milligrams that expired in November 2023.<br><br>b. One bottle of vitamin D that expired in May 2024.<br><br>c. One bottle of daily multivitamins with iron that expired in June 2024.<br><br>d. Three bottles of docusate sodium (stool softner), two expired in May 2024 and one expired in October 2024.<br><br>During an interview on 02/26/2025 at 2:57 PM with Licensed Practical Nurse Manager #1 and Licensed Practical Nurse #1, Licensed Practical Nurse #1 stated all nurses check for expired medications when they pull them from the medication storage room. Licensed Practical Nurse Manager #1 stated audits of the medication room were completed monthly and expired medications should be thrown away.<br><br>Review of a facility document Med Room Audit dated 09/26/2024, revealed the last documented North Unit medication storage room audit had no expired medication bottles identified.<br><br>During an interview on 02/28/2025 at 1:48 PM, the Director of Nursing stated the expired medications had most likely been pushed to the back of the shelf and not found during audits and expired medications should be removed from the medication rooms and discarded.<br><br>10 NYCRR 415.18(e)(1-4) |