

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Oak Hill Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 602 Hudson St Ithaca, NY 14850	

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 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>33418</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 3/17/2025-3/19/2025, the facility did not ensure the resident environment remained free of accident hazards for 1 of 3 residents (Resident #40) reviewed. Specifically, Resident #40 had medication at their bedside not ordered by the medical provider and the resident was not evaluated for the ability to self-administer medications.</p> <p>Findings include:</p> <p>The policy Storage of Medications, dated 6/2024 documented the facility stored all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff was responsible for maintaining medication storage and preparation areas.</p> <p>Resident #40 had diagnoses including chronic kidney disease and chronic pain. The 11/30/2024 Minimum Data Set assessment documented the resident was cognitively intact, required supervision or touch assistance for most activities for daily living, did not have pain, and did not receive scheduled or as needed pain medications as part of a pain management program in the previous 5 days of assessment.</p> <p>The Comprehensive Care Plan initiated 8/23/2024 and revised 3/18/2025 documented the resident was at risk for pain. Interventions included monitor and record any verbal or non-verbal signs of pain; assess effectiveness of pain relief measures; and administer medication as ordered. The Comprehensive Care Plan initiated 8/26/2024 documented the resident reported they sometimes needed assistance with instructions, or written material from a doctor or pharmacy. The interventions included the use of specific concrete instructions.</p> <p>The 8/23/2024 Physician Assistant #12 order documented the resident was to receive two, 500 milligram tablets of acetaminophen (pain medication), as needed, every 8 hours for chronic pain.</p> <p>The March 2025 medication administration record documented the resident did not receive any acetaminophen.</p> <p>During an interview and observation on 3/17/2025 at 3:23 PM, Resident #40 had a bottle of acetaminophen 650 milligram tablets at their bedside. The resident stated they took it a few times a week for left leg pain.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observations on 3/18/2025 at 10:20 AM and 3/19/2025 at 10:00 AM, the bottle of acetaminophen 650 milligram tablets remained on the resident's windowsill.</p> <p>During an interview on 3/19/2025 at 10:10 AM, Certified Nurse Aide #7 stated medications or inhalers were not supposed to be in resident rooms. It was a safety concern and if they saw medications in a room they would report it to the nurse. They did not notice the bottle of acetaminophen on the resident's windowsill.</p> <p>During an interview on 3/19/2025 at 10:15 AM, Licensed Practical Nurse #10 stated they were not aware of any residents who were care planned to self-administer medications. They were not sure that was even an option for the residents at the facility. They were able to have a physician order to leave the medication or inhaler at the bedside. They had not noticed Resident #40 had a bottle of acetaminophen on their windowsill. Resident #40 had an as needed order for acetaminophen but did not ask for it.</p> <p>During an interview on 3/19/2025 at 11:23 AM, the Director of Nursing stated the facility did not have any residents with the ability to self-administer medications. They expected medications found at a resident's bedside be removed immediately. The physician and the Director of Nursing should be notified. They would not know if the resident was taking the medications or not if the medication was left in the resident's room.</p> <p>10 NYCRR 415.12(h)(l)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48895</p> <p>Based on observations and interviews during the recertification survey conducted 3/17/2025-3/19/2025, the facility did not ensure drugs and biologicals were stored in accordance with professional principles to include storage in a locked compartment under proper temperature control and permitted only authorized personnel access for 1 of 1 storage area (first-floor clean utility room) reviewed. Specifically, the first floor medication refrigerator was unlocked and stored in an accessible clean linen room; and the medication refrigerator contained several temperature sensitive medications and was out of proper temperature range.</p> <p>Findings include:</p> <p>The facility policy Medication Refrigeration Policy, dated 5/2024 documented the refrigerator must maintain a tight range of 35 to 45 degrees Fahrenheit. Maintenance should be called for inspection for any temperature out of range.</p> <p>The facility policy Storage of Medications, dated 6/2024 documented compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use. Only persons authorized to prepare and administer medications should have access to the medication room, including any keys.</p> <p>During an observation on 3/17/2025 at 12:05 PM, the Director of Maintenance granted the surveyor access to the clean utility room next to the nursing station on the first floor. The clean utility room included resident care items. In the back of the room there were 2 refrigerators, one with beverages and one with medications. The medication refrigerator did not have a lock and contained glargine (long acting insulin), resident specific insulin pens, acetaminophen suppositories, semiglutide injection pens (diabetic medication), and a tuberculin skin test vial.</p> <p>During an interview on 3/18/2025 at 9:19 AM, Certified Nurse Aide #7 stated the clean utility room was accessible to everyone. Housekeeping, maintenance, therapy, certified nurse aides, activities, nurses, and anyone that needed to get something to care for a resident could access the room. The room had all types of items to provide resident care such as incontinence briefs and bathing supplies.</p> <p>During an observation on 3/18/2025 at 9:24 AM, Certified Nurse Aide #7 provided the surveyor the access code to the clean utility room next to the nursing station on the first floor. The medication refrigerator did not have a lock on it. The refrigerator contained 4 boxes of semiglutide injection pens, insulin pens, eye drops, and tuberculin skin tests. There was clear liquid pooling at the bottom of the refrigerator, and the eye drops box was soaked with the clear liquid. The refrigerator thermometer on the inside shelf documented 40 degrees Fahrenheit.</p> <p>During an observation on 3/18/2025 at 2:25 PM, the phone list at the first-floor nurse's station documented the code for access to the clean utility room, as Nurses Door.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/2025 at 2:34 PM, Certified Nurse Aide #8 stated general resident care items were stored in the clean linen/oxygen storage room next to the nurse's station. They did not think there were medications stored in the utility room, except in the medication refrigerator. The refrigerator used to be at the nurse's station with a lock on it. They thought the refrigerator in the clean utility room should have a lock on it.</p> <p>During an observation on 3/18/2025 at 3:08 PM, the first-floor clean utility medication refrigerator thermometer documented 60 degrees Fahrenheit. Clear liquid pooled at the bottom of the refrigerator and saturated the boxes of medications stored on the floor of the refrigerator.</p> <p>During an observation and interview on 3/18/2025 at 3:13 PM, Licensed Practical Nurse # 9 stated the medication refrigerators should be locked. Licensed Practical Nurse #9 entered the clean utility room and stated the refrigerator did not have a way to be locked. The refrigerator was 60 degrees Fahrenheit. It was the responsibility of the night shift to check the temperatures of the medication refrigerator. They stated all the items at the bottom of the refrigerator were soaked through. The semiglutide injection pens instructions were dripping wet. Licensed Practical Nurse #9 stated maintenance was looking at the refrigerator earlier in the day, but did not know the outcome. They stated the refrigerator was unsecured and anyone could walk in and take something from it.</p> <p>During an interview on 3/19/2025 at 11:21 AM, the Director of Nursing stated the first-floor medication refrigerator was in the clean utility room. There should be a lock on the refrigerator. They expected to be notified if medications were left unsecured, and they had not been notified the first-floor refrigerator was unlocked. The certified nurse aides, nurses, and anyone on that unit had access to the clean utility room. They stated that anyone could walk in and take those medications. The refrigerator was moved into the clean utility room from the nurse's station a few weeks ago and it should have a lock on it. When the medication refrigerator was observed at 60 degrees all the medication should be discarded and be replaced.</p> <p>10 NYCRR 483.45 (g)(h)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>48895</p> <p>Based on observations and interviews during the recertification and abbreviated (NY00371301) surveys conducted 3/17/2025-3/19/2025, the facility did not provide each resident with a nourishing, palatable, well-balanced diet that met their daily nutritional needs for 2 of 2 meals (the 3/17/2025 and 3/18/2025 lunch meals) reviewed. Specifically, the 3/17/2025 lunch meal had a cold dessert served outside the appropriate temperature range, food items were missing, the texture of food items were not palatable, and the meal ticket directions were not followed; and the 3/18/2025 lunch meal tray had an item missing from the tray.</p> <p>Findings include:</p> <p>The facility policy Tray Identification, dated 4/2024 documented the Food Service Manager or Supervisor checked trays for correct diets before the food carts were transported to their designated area. Nursing staff should check each food tray for the correct diet before serving the residents.</p> <p>The facility policy Food Temperatures, revised 10/2024 documented all cold food items must be maintained and served at a temperature of 41 degrees Fahrenheit or below.</p> <p>During an observation and interview on 3/17/2025 at 12:22 PM, an unidentified certified nurse aide on the first floor stated the food cart that was delivered had no milk for any of the resident's trays.</p> <p>During a first floor lunch meal observation on 3/17/2025 at 12:22 PM Resident #12 was served their lunch tray. The resident's tray could not be reproduced as the kitchen did not have any main entree left. Resident #12 requested a sandwich, milkshake, and apple juice. The kitchen did not have any apple juice, and the resident received orange juice. Resident #12 original meal tray was tested and verified with Certified Nurse Aide #13. The mixed fruit measured at 71.2 degrees Fahrenheit and was not listed on the meal ticket; the bread was placed across the spinach and pasta and was drenched with fluid; and the tray was missing 4 ounces of water, butter, and upside-down cake. The meal ticket documented no sauce or gravy on the tray, place the gravy on the side. The meat sauce was spread across the top of the pasta.</p> <p>During an interview on 3/17/2025 at 12:24 PM, Certified Nurse Aide #13 stated the piece of bread laying on top of Resident #12 spinach and pasta looked bad. The bread soaked up the liquid from the spinach and pasta. They stated residents complained about the food. The residents said they did not get all the items listed on their ticket, hot food was not hot, cold food was not cold, and they just did not like the food.</p> <p>During a second floor lunch meal observation on 3/18/2025 at 12:04 PM Resident #44 was served their lunch meal tray and a replacement was requested. The tray was missing the diet soda as planned and was verified with Registered Dietitian #15.</p> <p>(continued on next page)</p>		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/19/2025 at 10:02 AM, Dietary [NAME] #14 stated the kitchen was short staffed, and the kitchen would sometimes not have enough of the food the residents ordered. There was supposed to be a par list. They did not have production sheets. They counted meal tickets and pulled the items, and they might not have enough of the items ordered. They stated three residents ordered the chicken, but they only had two servings; and nine residents ordered fish, and they had none on hand. When the kitchen ran short the Food Service Manager went to the grocery store and bought needed items. The trays were checked by the kitchen staff before they left the kitchen, but sometime things were missed. They stated meal tray items should match the tickets, so the residents got what they asked for. The mixed fruit was a cold dessert and should be served at a temperature of less than 40 degrees Fahrenheit. The mixed fruit at 71 degrees Fahrenheit was too warm. Food should look and taste appetizing. The best placement for the slice of bread would have been in a small bag on the side, but it went on the plate with the other items. The bread could become soggy when put with other items. If the residents did not like the food, they could refuse to eat which could cause weight loss.</p> <p>During an interview on 3/19/2025 at 10:15 AM, the Food Service Manager stated they had complaints about the food every now and then, mostly the menu was repetitive. They did not know who decided the menu rotation. Meal trays should match the tickets. The kitchen had two people read the ticket and they hoped to catch everything correctly before the tray left the kitchen and went to the resident. It was important for them to match to keep the resident happy. If the kitchen was unable to provide an item on the meal ticket, they tried to replace it with something equal. Mixed fruit was a cold dessert and should be served at approximately 33-38 degrees Fahrenheit, 71 degrees Fahrenheit was not an acceptable temperature for mixed fruit. The food should look and taste appetizing. When bread was served it should be place separately from pasta, because it could get soggy when placed on top of the food. There were times the kitchen ran out of a main entree or an alternative food item. They stated if they were in the building when items were short, they went to the store to purchase the items needed. They determined how much to order based on a notebook they created with menu ingredients. They wrote down the order and gave it to the Administrator to place the order. The kitchen was short staffed and had been for several months.</p> <p>10NYCRR 415.14</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43754</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 3/17/2025-3/19/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 main kitchen. Specifically, in the main kitchen food was not properly stored or labeled; there were multiple unclean and uncleanable surfaces; and food products and equipment in the storage areas were below wastewater lines.</p> <p>Findings include:</p> <p>The facility policy Sanitization, revised 5/2024 documented the food service area should be maintained in a clean and sanitary manner. The kitchen and dining room surfaces not in contact with food should be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. The Food Services Manager was responsible for scheduling staff for regular cleaning of the kitchen and dining areas. Food service staff were trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.</p> <p>During an observation of the main kitchen on 3/17/2025 between 9:51 AM and 12:25 PM;</p> <ul style="list-style-type: none"> - there were dried food spills in the double door cooler and the cart next to the cooler had clean lunch trays coated with dried on dust, grease, and debris. - the back wall of the 3-bay sink was soiled with dried food splatters and the lower shelving and drawers had dried food debris, dust, and grease. - the floors in the dish room were soiled with blackened grease and grime. - the wall behind the dish machine was heavily soiled with food splatters, grease, and grime. - the wall by hand sink was heavily soiled with food splatters, grease, and grime. - the floor around and under the ice machine was heavily soiled. - the ice cream freezer at the end of the freezer row was heavily encased in ice, about 3-8 inches into the cooler, on all sides. - there was food and debris on the floor of the storage rooms, some canned goods and a case of paper cups were soiled by a red liquid spilling down through the shelving and dried onto the products. There was a shared wall to the Central Supply room with unfinished drywall that was not smooth and easily cleanable. - the dry storage room had a freezer located under an 8-inch drain line that extended across the room and hung over the wall's shelving for canned goods, drinks, individual packaged condiments, and clean pans. Milk and supplement drinks were stored under wastewater lines in the connecting storage room. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - the tile floor in the hall outside the kitchen was in disrepair. The area held meal carts waiting to go in the dish room. The floor was heavily soiled and littered with debris. - the kitchen floors were soiled with built up black grease and grime. The grease and grime was heavier under equipment and preparation tables. - the kitchen storage room had unfinished plywood and 2 by 4 construction for shelving atop the gated entrance that was not smooth and easily cleanable. <p>During an observation of the main kitchen on 3/18/2025 between 12:00 PM and 12:31 PM:</p> <ul style="list-style-type: none"> - there was an unlabeled pitcher in the single door cooler. - there was a flat of raw unpasteurized eggs stored above a crate of milk. - the kitchen floors and walls were heavily soiled by food splatters, grease, and grime. - the dish machine was soiled on the outside, and the floor drain beneath appeared to have been clogged recently from the food debris and was washed against the base of the walls. <p>During an interview on 3/18/2025 at 2:03 PM, the Food Service Manager stated the kitchen should be cleaned every shift, but they were short staffed. The floors were cleaned by sweeping and mopping, and they were trying to get enough staff to do a good deep clean, and only had four kitchen staff total. The walls should be cleaned once a month but had not been done much. The walls in the dish area were cleaned whenever they got to it. They did not document the cleaning of the kitchen. It was important to keep the kitchen preparation areas and storage areas clean to prevent cross contamination and to keep everything sanitary. They did not think food products or equipment should be stored under wastewater lines, because it was not sanitary. The bare wood shelves and drywall was not smooth or easily cleanable. All food should be properly labeled, including the pitcher. It was important so all staff knew what the items were and what it was used for, how long it had been there, and when to use it or not use it. Raw eggs should not be stored over any ready to eat item due to potential for cross contamination.</p> <p>10NYCRR 415.14(h)</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>43754</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 3/17/2025-3/19/2025, the facility did not ensure garbage and refuse was disposed of properly. Specifically, facility garbage areas were not maintained to prevent attraction and harborage of pests.</p> <p>Findings include:</p> <p>The facility policy Smoking, revised 4/2024 documented the smoking area should be kept neat, clean, and attractive. Ashtrays should always be used when smoking.</p> <p>The facility policy Food-Related Garbage and Refuse Disposal, revised 5/2024 documented food related garbage and refuse were disposed of in accordance with current state laws. All garbage and refuse containers were provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. The outside dumpsters provided by the garbage pickup service were kept closed and free of surrounding litter.</p> <p>During an observation and interview on 3/17/2025 at 1:30 PM, there were multiple piles of garbage and debris around various outbuildings, dumpsters, and shipping containers on site. There was garbage littering the tree line at the edge of the property and piles of pallets and construction material that were harborage areas for pests. The dumpsters were left open and there was a bag of garbage on the ground beside the dumpster. The Director of Maintenance stated the bag was left accidentally and been frozen to the ground, the dumpster company kept setting the dumpster back on top of it, and they did not want the bag to rip. They kept missing the dumpster company when they came onsite to have them move the dumpster so they could throw the bag out. They stated the metal was set aside for recycling.</p> <p>During an observation on 3/17/2025 at 5:13 PM, the staff smoking area included a smoking tower and metal ashtray that was tipped over with the lid left open and a plastic bag of garbage spilled out on the ground.</p> <p>During an observation on 3/18/2025 at 10:03 AM, the staff smoking area included a smoking tower and metal ashtray that was tipped over with the lid left open and a plastic bag of garbage spilled out on the ground. The dumpsters were open with garbage bags hanging out the top and bags on the ground beside the dumpster.</p> <p>During an observation of the staff smoking area and interview on 3/18/2025 at 12:45 PM, the Director of Maintenance stated staff smoked by the dumpsters. There was an ashtray by the dumpsters. The ashtray was a metal can with a self-closing lid and contained garbage and cigarette butts.</p> <p>During an interview on 3/18/2025 at 1:52 PM, the Food Service Director and Dietary Aide #17 stated they did not know the metal can in the smoking area was an ashtray.</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 - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46276</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 3/17/2025-3/19/2025, the facility did not 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 including legionella (a type of bacteria found in water which can cause Legionnaires' disease); and did not handle, store, process, and transport linens and laundry in accordance with accepted standards to produce hygienically clean laundry and prevent the spread of infection for 1 of 1 laundry room reviewed. Specifically, there was no facility assessment for legionella, annual sampling for legionella was not conducted in 2024, legionella sampling completed in 2023 and 2025 did not include sampled sites in the water management plan; and the laundry room did not have a separated entry/exit area for the flow of dirty and clean linens to prevent cross-contamination of resident personal laundry.</p> <p>Findings include:</p> <p>Legionella</p> <p>The facility's plan titled Sampling and Management Plan, created on 10/2024 documented Legionella culture sampling and analysis was conducted annually. Areas to be sampled included:</p> <ul style="list-style-type: none"> - Inlet of the heating system, - Outlet of the heating system - Inlet of the cold-water supply - Area closest to first delivery of hot water - Area in the middle of hot water delivery - Area of last outlet before the water returns to the heater - Area where multiple risers supply hot water to a limited number of rooms from a circulation loop - Floors that housed patients/ residents. A minimum of four samples were to be collected (faucet fixtures, shower areas, etc.). <p>The last documented review of the facility's water management plan for Legionella was October 2023 and January 2025. There was no documented evidence the annual review of the Legionella program or testing sampling was completed in 2024, or culture sampling for 2023 and 2025 was obtained for the heating systems, cold water supply, or areas of first, middle, or last outlets as per the facility water management plan.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Oak Hill Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 602 Hudson St Ithaca, NY 14850	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/18/2025 at 4:25 PM, the Director of Maintenance stated they ordered legionella testing kits from an outside agency and the kits contained sampling tubes with instructions on how to obtain the samples. They were responsible for the culture sampling for legionella and thought they obtained them in 2024, and the Administrator had the records.</p> <p>During an interview on 3/19/2025 at 3:21 PM, the Administrator stated they had not found legionella testing results for 2024 and thought they completed testing in 2024. They contacted the lab for results and the lab could not locate results for 2024. It was important to do annual testing for legionella to ensure the facility had safe water.</p> <p>Laundry Room</p> <p>There was no documented evidence of laundry or linen processing policy.</p> <p>During an observation and interview on 3/18/2025 at 1:28 PM, there was one entry and exit doorway for the laundry room. When entering the laundry room, there was a small closet to the left with hanging clean clothes and five bags of resident personal clothing on the floor in the closet. There were three washing machines, a utility sink in a corner between two washing machines, and two large front-loading dryers. The laundry room was approximately a 10-foot by 8-foot space. Laundry aide #4 stated the clothes in the closet were clean, not labeled, and were considered missing items since they were not labeled. Laundry aide #4 stated they were responsible for washing and drying resident's personal clothing for the entire building. The bags of clothing on the closet floor were dirty and should not be mixed with clean clothing. They did not have bins to place dirty clothing in because the owners did not want them to cross contaminate dirty and clean clothing when coming into and out of the laundry room door. Laundry aide #4 stated they did not have any room in the washing area to keep the dirty clothing, so the dirty clothing was placed in the clean closet area. It was important to keep dirty and clean clothes separate.</p> <p>During an interview on 3/18/2025 at 3:42 PM the Corporate Registered Nurse Infection Preventionist stated the facility was aware of the laundry room only having one entrance/exit and they knew about it for quite some time. The facility lacked the space to have a larger room with multiple entrances or exits. Currently the clean and dirty laundry passed one another. It was not appropriate for five bags of dirty clothing in the closet to be in the same area as clean laundry. There were many residents on enhanced barrier precautions for multiple drug resistant organisms and other conditions that could potentially spread infection.</p> <p>10NYCRR 415.19(a)</p>		