STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335233	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 33421 Based on record review and interview during the recertification and abbreviated (NY00340720) surveys conducted 7/15/2024-7/22/2024, the facility did not immediately inform the resident's representative when there was a need to commence a new treatment for 1 of 2 residents reviewed (Resident #525). Specifically, Resident #525 was prescribed an antibiotic for symptoms of infection and the resident's representative was not notified. Findings include: The facility policy, Change in a Resident's Condition or Status, last revised 1/2024, documented the facility promptly notified the resident, their attending physician, and representative of changes in the resident's medical/mental condition and/or status. Except in medical emergencies, notifications were made within 24 hours of a change that occurred in the resident's medical/mental condition or status. Resident #525 had diagnoses including stroke, sacral (lower back) pressure ulcer, and a history of infections. The 4/16/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had a urinary tract infection in the past 30 days, and had not received antibiotics in the previous 7 days. The 4/10/2024 comprehensive care plan for cognition documented the resident had long term, non-correctable impaired cognitive function or thought process, and was at risk for drug complications. Interventions included communication with family regarding capabilities and needs, concerns were discussed with family, family was educated on potential side-effects of medications, and medications were provided as ordered. A 4/23/2024 Nurse Practitioner #26 progress note documented the resident was seen for an elevated white blood cell count of 14.51 (normal 4.8-10.0). The plan was to start Doxycycline 100 milligrams by mouth twice daily for 7 days for infection; chest x-ray; and repeat labs on Friday (4/26/2024) to follow up on white blood cell count. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/23/2024 Physician # 27 progress note documented the resident was seen for follow-up regarding recent lab results following a hospitalization for a stroke with a cardiac history. The plan included treatment with ceftriaxone sodium 1 gram intramuscularly every 24 hours for 5 days to address the infection effectively. Close monitoring of the patient's response to treatment and symptomatology would be paramount. Further follow-up appointments would be scheduled as deemed necessary based on clinical progress and ongoing evaluation of lab results. A 4/24/2024 Physician #27 progress note documented they reviewed chest x-ray results following recent hospitalization for stroke with cardiac history. Chest x-ray findings revealed mild left basilar (left lung base) atelectasis (collapse of lung), otherwise the lungs were clear. The plan was to continue doxycycline for 7 days for elevated white blood cell count with wounds and cough. Any changes in symptoms or clinical status would be monitored. A follow-up would be scheduled for reassessment as needed. Physician orders documented: - on 4/23/2024 doxycycline (antibiotic) 100 milligrams twice a day for 7 days for infection, elevated white blood cells, wound and cough. - on 4/24/2024 ceftriaxone sodium (antibiotic) inject 1 gram intramuscularly every 24 hours for 5 days for infection. The 4/23/2024, 4/24/2024, 4/25/2024, and 4/25/2024 progress notes by Registered Nurse # 28 did not document signs or symptoms of infection, the use of antibiotics, or notification of the resident's representative regarding infection and use of antibiotics. There was no documented evidence the resident's representative was notified when the resident required the use of antibiotics for infection. During a telephone interview on 7/18/24 at 1:20 PM the resident's representative stated they did not receive notification from the facility when the resident was started on antibiotics for an infection in 4/2024. During an interview on 7/22/2024 at 2:50 PM, the Director of Nursing stated family should be notified if a resident was started on antibiotic therapy. The notification should be done within a couple of hours by the nurse who obtained the order. The family was not notified about the resident starting antibiotics and should have been. There were no nursing progress notes, and there should have been. 10NYCRR 415.3(e)(2)(ii)(b,c)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 44838 Based on record review, observation, and interview during the recertification and abbreviated (NY00340720) surveys conducted 7/15/2024-7/22/2024, the facility did not ensure they had a process in place for residents to have their grievances addressed appropriately for 13 of 13 (12 anonymous residents, and Resident #16) reviewed. Specifically, 12 anonymous residents present at the Resident Council meeting stated they did not know who the grievance officer was, how grievances were handled, or receive communication on the progress of grievance resolutions; and Resident #16 filed a grievance regarding a care concern that was not resolved. Findings include: The facility policy, Filing Grievance Complaints, last reviewed 1/2024, documented the facility must establish a grievance policy that ensured the prompt resolution of all grievances regarding the residents' rights. The facility assisted residents in filing grievances and/or complaints when such requests were made. The facility notified residents individually or through postings in prominent locations throughout the facility of the right to file grievances either orally (meaning spoken) or in writing. The facility ensured that all written grievance decisions included the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern, a statement as to whether the statement was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. The New York State Department of Health document Your Rights as a Nursing Home Resident, was included in the admission packet provided to residents and documented a resident had the right to be cared for in a manner that enhanced quality of life, freedom from humiliation, harassment, or threats. Rights of self-determination were to receive services with reasonable accommodations for individual needs and preferences, and to participate in the planning of care and services. Rights for complaints expected the facility investigated and tried to resolve concerns promptly. During a Resident Council Meeting on 7/15/2024 at 1:57 PM, twelve anonymous residents stated they were unaware of who the facility grievance officer was. They reported their concerns to their social worker or the Administrator. They stated they did not always receive follow up on their expressed grievances. During an observation on 7/15/2024 at 2:45 PM the phone number for the New York State Complaint hotline labeled Patient Care Hotline and the New York State Ombudsman poster were in a glass case by the Administrator's office. There was no facility grievance officer or contact information posted. 1) Resident #16 had diagnoses including cerebral palsy (damage to the brain causing movement disorders), anxiety disorder, and depression. The 5/10/2024 Minimum Data Set admission assessment documented the resident had intact cognition, did not have behavioral symptoms, did not reject care or wander, used an electric wheelchair, and was dependent on staff for most activities of daily living. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 5/6/2024 Comprehensive Care Plan documented the resident was at risk for an adjustment problem related to a new environment. Interventions included encourage family involvement, provide emotional support and encouragement, and allow the resident the opportunity to express himself/herself. During an interview on 7/15/2024 at 10:32 AM, Resident #16 stated Certified Nurse Aides #20 and #21 were touchy/feely with each other while providing care. They touched each other on their butts and private areas, and this made the resident very uncomfortable. The resident felt this was unprofessional and reported it to Registered Nurse Unit Manager #5. The resident did not want to be cared for by these staff members anymore and did not feel the facility addressed their concerns. All grievances for May 2024-July 2024 were requested. There was one grievance dated 6/5/2024 for Resident #16. The grievance form dated 6/5/2024 documented Resident #16 expressed concern they asked Certified Nurse Aides #20 and #21 to unlock the door for family members that were trying to visit. The staff responded to the resident, You'll have to figure that out yourself. The delegation of responsibility was listed as the Nursing department and Administration. The follow up action was both staff members were educated on customer service. The social service follow-up documented the resident was aware the incident was being investigated. The action taken summary was blank, the report was provided to and signed by the Administrator on 6/7/2024. There was a handwritten summary of the complaint by Registered Nurse Unit Manger #5 that outlined the incident. A 6/7/2024 form addressed to the resident documented their grievance had been addressed and action had been taken to resolve the issue. The document was unsigned and did not include the outcome of the investigation, the action taken, or if the resident was apprised of the grievance outcome. There was affirmation of re-education signed by Certified Nurse Aide #20 that documented one of the topics reviewed was professionalism with co-workers and residents. There was no documented reeducation for Certified Nurse Aide #21. During an interview on 7/19/2024 at 1:26 PM, Social Worker #16 stated if they were notified of a grievance, they filled out a grievance form. They interviewed the resident, and then delegated the investigation to the appropriate department head. They followed up daily to make sure it was resolved. Grievances were only supposed to be open a maximum of 3 days. Once resolved they reported the findings to the resident or the family. Resident #16's grievance dated 6/5/2024 was documented as resolved, and they had multiple verbal conversations with the resident, but did not document those. The resolution was education on Customer Service with the staff involved. The resident was not completely satisfied with the resolution. The resident did not want Certified Nurse Aide #20 to provide care to them anymore. The Social Worker believed that was a resident right. They had repeatedly communicated this to nursing and were not sure if anything had been done about it. There were 2 certified nurse aides involved and only one was educated. Both certified nurse aides should have been educated. It was important to residents to improve their quality of care and honor their rights. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/19/2024 at 1:54 PM, Registered Nurse Unit Manger #5 stated they interviewed Resident #16 regarding an incident 6/5/2024 involving Certified Nurse Aides #20 and #21, not letting visitors in when requested. They wrote a statement and provided it to either the Director of Nursing or the Assistant Director of Nursing. It was then out of their hands, and an investigation should have been completed. The resident had also complained about the same 2 certified nurse aides touching each other inappropriately, and breaking the resident's fan while care was provided. They stated they told the Director of Nursing or the Assistant Director of Nursing. They did not document the incidents and realized they should have. Residents should have their choices honored about not being provided care by a staff member that made them uncomfortable. During an interview on 7/19/2024 at 3:24 PM, the Director of Nursing stated care concerns should be reported to the Director of Nursing or the Assistant Director of Nursing. It would then go up the chain of command, ultimately ending up with Administration. The resident and staff involved were interviewed and would be documented in a file. They did not have a file for Resident #16's complaints other than the one dated 6/5/2024. Depending on what was determined they would go forward and there may be education of staff if needed. They did not recall reports of care concerns for Resident #16. All staff involved in the incident should have been educated. A resident had the right to request not to receive care from a staff member that made them feel uncomfortable and the assignment could be changed if needed. This should be communicated to Supervisors, and the Director of Nursing or the Assistant Director of Nursing should be aware of the concerns. They stated they knew about the resident's fan getting broken, and provided a During an interview on 7/19/2024 at 3:40 PM, the Administrator stated resident concerns should be brought to the attention of the Director of Nursing or the Assistant Director of Nursing and the Administrator in a timely fashion. Grievances should be closed out within 72 hours. It was a resident's right to ask that a staff member they were uncomfortable with not provide care. Grievance resolution should be documented, and education should be provided to all staff involved. During an interview on 7/19/2024 at 3:51 PM, the Nursing Staffing Coordinator stated they were notified by Registered Nurse Unit Manager #5 on 7/8/2024 to try to keep Certified Nurse Aide #20 on Unit 1 (a different Unit than Resident #16 resided on). They were not notified by the Director of Nursing or the Assistant Director of Nursing. 10NYCRR 415.3(C)(1)(ii) 49448

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 44838 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure residents were provided an ongoing program to support their choice of activities, designed to meet their interests and support their physical, mental, and psychosocial well-being for 1 of 2 residents (Resident #3) reviewed. Specifically, Resident #3 was not provided a large print Bible or glasses to meet their interests and preferences. Findings include: The facility policy, Activity Programs, effective 1/2022, documented activity programs were designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Activities offered were based on the comprehensive resident based assessment and the preferences of each resident. Adequate space and equipment were provided to ensure that needed services identified in the resident's plan of care were met. Resident #3 had diagnoses including left sided hemiplegia (paralysis or weakness to one side of the body), unspecified visual loss, and depression. The 6/17/2024 Minimum Data Set assessment (health status assessment tool) documented the resident had intact cognition, impaired vision (sees large print, but not regular print in newspapers/books), did not have corrective lenses, felt down, depressed, or hopeless, exhibited behavioral symptoms, rejected care, and required staff assistance for activities of daily living. The Comprehensive Care Plan documented the following: - initiated 1/4/2019 and revised 7/6/2023 the resident was able to make activity preferences known. The resident stated they preferred independent activities and 1:1 visits and could benefit from encouragement. Interventions included provide the resident with personal 1:1 bedside visits and provide equipment/supplies necessary for in room participation. Interests included socializing with staff, signing up for the monthly shopping trip, current events/history, and religious pursuits and reading their large print Bible. - initiated 10/5/2020 and revised 10/15/2021 the resident had impaired visual function status post stroke. They were unable to read newspaper print and required readers or magnifier. The resident refused a vision exam on 7/14/2021. Goals included the resident would use appropriate visual devices to promote participation in activities of daily living and other activities. through the review date. Interventions included ensure appropriate visual aids were available to support participation in activities. The activities quarterly assessment completed 6/11/2024 by Activities Director #14 documented current participation was in self-directed independent pursuits and 1:1 activities in their room. The assessment did not include specific independent pursuits or 1:1 activities, or if the resident had a large print Bible as planned. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The monthly activity calendar was used to track the resident's participation in activities. The calendar had attended activities highlighted in varying colors. Documentation for May-July 2024 included room visits 5 days weekly. During an observation and interview on 7/15/2024 at 10:55 AM, Resident #3 was in bed in a hospital gown. They stated they did not get out of bed or participate in group activities. They stated their glasses were lost and they needed them to watch television and to read. They liked to read the Bible. They were not sure where their Bible was and thought someone probably took it. During an interview on 7/22/2024 at 10:00 AM Certified Nurse Aide #14 stated that they were not aware Resident #3 was missing glasses. During an interview on 7/22/2024 at 10:12 AM, Licensed Practical Nurse #1 stated resident care information was found in the care plan. The care plan should list glasses if they were needed, and missing glasses should be reported. They were not aware that Resident #3 was missing glasses or their Bible. During an interview on 7/22/2024 at 10:54 AM, Activities Director #14 stated they did all quarterly assessments. Individual records for activities participation were kept by highlighting the activity calendar. 1:1 visits were supposed to be approximately 20 minutes and included engaging with the resident in their areas of interest. Resident interests were listed in resident's care plans. The care plans were reviewed by activity aides, so they were familiar with resident preferences. Refusals of offered activities should have a R next to them. If a resident refused activities, it should be reported to the director. Their job was to make sure their interests could be accomplished by providing supplies. If a resident needed reading glasses, they could provide them. Resident #3's care plan documented the need for glasses and a large print Bible. The resident had no glasses in their room. They provided a Bible to the resident over the weekend. The Bible was not large print and should have been. During an interview on 7/22/2024 at 11:21 AM, Activity Aide #15 stated their responsibilities included assisting residents with activities scheduled on the calendar. They also provided 1:1 visits which included arm massages, games, and making sure residents had what they needed for individual activities. The Activity Director usually let them know what residents' likes and dislikes were. They did not usually review each resident's care plan. Documentation was kept in a binder for each resident. Highlighting on the calendar meant the resident took part in the activity. They visited Resident #3 every morning for about 10 minutes and asked them how their day was going, and the resident would sometimes accept packets of activities. They were not sure if the resident needed glasses. 10 NYCRR 415.5(f)(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44838 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 3 residents (Residents # 27and #67) reviewed. Specifically, Residents #27 and #67 had physician orders for air low air loss mattresses (a specialty mattress that provides air flow to relieve pressure) that did not include settings and were not monitored to ensure appropriate settings for current weights. Findings include: The undated facility policy, Air Mattress Guidelines, documented a low air loss mattress was a mattress designed to prevent and treat pressure wounds. Residents were assessed for the appropriateness of an air mattress upon admission based on risk factors and /or the existence of actual or history of pressure injuries. An air mattress was provided to those residents to prevent skin breakdown, promote circulation, and provided pressure relief or reduction. Residents baseline weight was considered as well as any contractures or positioning/mobility concerns that may affect the effectiveness of a low air loss mattress. Staff checked at least daily that the air mattress was on, was set appropriately (if applicable) and functioning. 1) Resident #27 had diagnoses including a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer of the sacral (lower back) region, diabetes, and morbid obesity. The 4/23/2024 Minimum Data Set assessment (health status assessment tool) documented the resident had intact cognition, did not exhibit behaviors, did not reject care, required substantial assistance with bed mobility and transfers, weighed 211 pounds, had 1 stage 4 pressure ulcer. and had pressure reducing devices for bed and chair. The comprehensive care plan initiated 10/30/2023 documented: - the resident required assistance with self-care and mobility related to limited mobility and musculoskeletal impairment. Rolling left and right required substantial/maximal assistance, and the resident was dependent on a mechanical lift for transfers. - the resident had an alteration in skin integrity with an actual Stage 4 pressure ulcer related to impaired mobility. Interventions included bed pressure relieving device of a low air loss mattress. Physician orders documented: - on 1/5/2023 check air mattress every shift for bottoming out and proper function - on 3/25/2024 check weight setting and function every shift and as needed to avoid firmness and bottoming out, for mattress functionality and pressure relief. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/2/2024 Wound Evaluation and Management Summary completed by Wound Care Physician #4 documented the resident had a Stage 4 pressure wound on their sacrum measuring 5.8 centimeters x 2.5 centimeters x 2.0 centimeters with heavy serous (clear) drainage, and 100% granulation tissue (new connective tissue). Off-loading surfaces care plan was reviewed. The resident had a Group 2 support surface for their bed (a pressure-reducing mattress overlay or mattress that works by inflating tubes or cells with air). The 7/15/2024 Wound Evaluation and Management Summary completed by Wound Care Physician #4 documented the resident had a Stage 4 pressure wound on their sacrum measuring 5.5 centimeters x 1.5 centimeters x 1.0 centimeters. The wound had 20% slough (moist, dead tissue) and 80% granulation tissue. The wound had improved as evidenced by decreased surface area. The 7/2024 Treatment Administration Record documented check weight setting and function every shift and as needed to avoid firmness and bottoming out of air mattress and pressure relief with a start date of 3/25/2024. The mattress was signed as checked every shift (6:00 AM-2:00 PM, 2:00 PM-10:00 PM, and 10:00 PM-6:00 AM) from 7/1/2024-7/19/2024 except for 7/5/2024 2:00 PM-10:00 PM, 7/16/2024 6:00 AM-2:00 PM, and 2:00 PM-10:00 PM, 7/19/2024 2:00 PM-10:00 PM. The physician orders, Treatment Administration Record, and Comprehensive Care Plan did not document the settings for the low air loss mattress. The following observations of Resident #27 were made: - on 7/15/2024 at 2:33 PM the resident was in bed in a hospital gown. They complained of pain to the sore on their bottom. The low air loss mattress was set on static at 325 pounds. - on 7/16/2024 at 12:24 PM the resident was in bed with their eyes closed. The low air loss mattress was set on static at 325 pounds. - on 7/18/2024 at 1:33 PM the resident was transferred back to bed by 2 staff using a mechanical lift. The low air loss mattress was set on static at 325 pounds. 2) Resident #67 had diagnoses including aftercare for surgery of the digestive system, and unspecified intellectual disability. The 5/17/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not have behavioral symptoms, did not reject care, was dependent on staff for all activities of daily living, weighed 141 pounds, had no unhealed pressure areas, and had pressure reducing devices for their bed and chair. The comprehensive care plan initiated 5/10/2024 documented the resident was at risk for impaired skin integrity related to decline in mobility, incontinence, malnutrition. Revised on 5/22/2024 with interventions for turning and positioning, revised 6/26/2024 with intervention of air mattress. The comprehensive care plan initiated 6/18/2024 documented impaired skin integrity related to ulceration on left buttocks-stage 2 (wound with partial thickness skin loss). Intervention of apply treatment per physician's order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/24/2024 Wound Evaluation and Management Summary completed by Wound Care Physician #4 documented the resident had an unstageable (full thickness tissue loss in which the base of the ulcer was covered by slough, moist dead tissue, or eschar, dry dead tissue) on the left buttock. The wound measured 1. 7 centimeters x 1.2 centimeters x 0.1 centimeter, had 40% slough and 60% granulation tissue. The resident had a Group 1 support surface for their bed (a pressure pad for the mattress, non-powered pressure reducing mattresses, and powered pressure reducing mattress overlay system). The plan included a low air loss mattress (provides airflow to help keep skin dry, as well as to relieve pressure). A 6/26/2024 physician order documented check functionality, proper inflation, and positioning every shift and report to supervisor any issues, for wound. The order did include what was to be checked for functionality and proper inflation. The resident's weight was documented on 6/11/2024 at 138.2 pounds, and on 7/5/2024 at 141.2 pounds. The 7/2024 Treatment Administration Record documented check functionality, proper inflation and positioning every shift and report to Supervisor any issues, every shift for wound, with a start date of 6/26/2024. The Treatment Administration was signed as completed every shift (6:00 AM-2:00 PM, 2:00 PM-10:00 PM, and 10:00 PM-6:00 AM) from 7/1/2024-7/19/2024 except for 7/4/2024 2:00 PM-10:00 PM, 7/16/2024 6:00 AM-2:00 PM, and 2:00 PM-10:00 PM, and 7/19/2024 10:00 PM-6:00 AM. The physician order, Treatment Administration Record, and Comprehensive Care Plan did not document directions for settings for the low air loss mattress. The following observations of Resident #67 were made: - on 7/15/2024 at 12:25 PM the resident was in bed with their low air loss mattress set on alternating at 250 pounds. - on 7/16/2024 at 12:39 PM the resident was sleeping in bed with their low air loss mattress set on alternating at 250 pounds. During an interview on 7/19/2024 at 12:17 PM, Licensed Practical Nurse #1 stated low air loss mattresses were ordered and set up by maintenance. Nurses checked them for functionality and made sure all lights were on and the mattress felt inflated. They thought they were supposed to be set according to the resident's weight. It was important to make sure the weight was set correctly. They did not check if the weight was set correctly when documenting in the Treatment Administration Records. The resident's weight should be listed in the order to provide the correct setting to use. The mattress could be static or alternating, and they were not sure what Resident #27's was supposed to be set at. They observed the mattress and stated it was set at static at 325 pounds. It probably should be alternating due to the presence of pressure ulcers. They were not sure what Resident #67's settings were supposed to be. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/2024 at 12:25 PM, the Maintenance Director stated low air loss mattresses were installed by maintenance. Nursing verbally requested them to be put on the bed by maintenance. They needed to specify bariatric or standard. They were set by nursing to individual orders. The maintenance department did not monitor low air loss mattresses and would not have access to information to set the mattress controls. During an interview on 7/19/2024 at 12:38 PM, Registered Nurse Unit Manager #2 stated low air loss mattresses were used for residents with wounds or were at high risk for wounds. They provided pressure relief to certain areas for residents who could not move themselves. The mattresses were used to prevent wounds from occurring or to prevent worsening of existing wounds. Maintenance brought them to the unit, and they were not sure who set them. They did not set them and was not sure what criteria was used for settings. Nurses should be checking the mattresses for correct settings. Resident #27 had a bad wound, could not move themself, and chose to spend most of their time in bed. Low air loss mattress being set correctly was important. Resident #67 had a resolved pressure area on their buttock, which put them at increased risk for recurring pressure areas. During an interview on 7/19/2024 at 12:48 PM, the Director of Nursing (from a sister facility who was covering for the Director of Nursing on leave), stated low loss air mattresses were used for residents with wounds and immobility. They could be used to prevent formation of wounds or prevent worsening of wounds. They should be individualized by weight and either static or alternating settings. Nurses should be checking for the proper weight, bottoming out, and proper settings every shift. Resident #27 weighed 211 pounds and the mattress was set at 325 and that was likely too firm. The mattress was set to static, and they would benefit from alternating function due to presence of wound and limited mobility. During an interview on 7/22/2024 at 11:37 AM, Wound Care Physician #4 stated low air loss mattresses could help control moisture, prevent pressure, and maintain temperature for wound healing and prevention. If used correctly, they could help prevent new pressure areas from developing and help healing of existing areas. 10NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00314958) surveys conducted 7/15/2024-7/22/2024, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #7) reviewed. Specifically, Resident #7 had a diagnosis of dysphagia (difficulty swallowing) and was care planned for line-of-sight supervision for meals with specific swallowing strategies and was observed eating a meal alone in their room. Findings include: The facility policy, Meal Observation, reviewed 1/2024, documented nursing provided supervision and observation during mealtime, in dining areas and patient/ resident rooms. Staff ensured all residents received the appropriate consistency altered diets as ordered. The facility policy, Assistance with Meals, reviewed 1/2024, documented residents received assistance with meals in a manner that met the individual needs of each resident. Facility staff helped residents who required assistance with eating. Residents were fed with attention to safety, comfort, and dignity. Resident #7 had diagnoses including oropharyngeal dysphagia (difficulty initiating swallowing), anxiety, and diabetes. The 4/27/2024 Minimum Data Set assessment (a health assessment tool) documented the resident was cognitively intact, had unplanned weight loss, required supervision for eating, did not have a swallowing disorder, and received a mechanically altered diet. The comprehensive care plan initiated 1/26/2024 and revised 4/19/2024 documented the resident required assistance with self-care related to limited mobility. Interventions included supervision or touching assistance (line of sight supervision) with meals, chopped textures with the exception for chips, thin-small bites, single bites, alteration of sips and bites, upright positioning during and 30 minutes following intake. The resident had a nutritional problem related to a mechanically altered diet. Interventions included assist with feeding, encourage eating in dining room to promote socialization, encourage meal intake and completion, and observe for chewing and swallowing problems. The 2/1/024 physician order documented the resident was to receive a chopped texture diet with an exception for chips. A 5/7/2024 at 9:33 AM Speech Language Pathologist #6 discharge summary documented the resident demonstrated the ability to consume diet of chopped textures with exception of chips. The resident preferred chopped textures for chewing ease. Minimal to occasional cueing was need for recommended compensatory strategies including small single bites to maximize safety and efficiency during swallow and the resident should be upright during meals. The resident required distant supervision for oral intake and recommendations included line of sight supervision during intake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/19/2024 at 3:10 PM Registered Dietitian #29 progress note documented the resident's current diet order was no added salt, no concentrated sweets, chopped texture and thin liquids. The resident required supervision or touching assistance (line of sight supervision), small bites, single bites, alteration of sips and bites, and upright positioning during and 30 minutes following intake. The resident had no issues chewing/swallowing. The resident had lost 13.6% of their weight in 6 months (12/8/2023 201.8 pounds, 6/11/2024 174.4 pounds). The weight loss was likely related to fluid and increased energy expenditure. During an observation on 7/16/2024 at 12:32 PM, Resident #7 was seated on the side of their bed eating their lunch out of a divided scoop plate with plastic utensils with their back facing the door of their room. There was no staff present. Their meal ticket documented cheesy beef and rice casserole, brown gravy, black beans, cottage cheese, and chopped fruit mix. The care instructions active as of 7/22/2024 documented the resident required supervision or touching assistance with eating (line of sight supervision), chopped textures with exception of chips. Small bites, single bites, alteration of sips and bites, upright position during and 30 minutes following intake. During an interview on 7/22/2024 at 10:36 AM Certified Nurse Aide #7 stated if a resident was on a chopped or pureed diet, they were always supervised with meals. Resident #7 should be supervised at meals, and it was not appropriate they ate alone in their room. They could choke or anything bad could happen. Whoever took Resident #7 their lunch should have taken them to the dining room or stayed with them to supervise them eating their meal. During an interview on 7/22/2024 at 10:52 AM Registered Nurse Unit Manager #5 stated anyone on an altered diet, such as chopped, had a yellow meal ticket that alerted staff they had to be supervised with eating for safety. If a resident was on an altered diet, they were at risk for aspiration (food/liquids enter the lungs) or choking. They instructed the certified nurse aides to stay in the resident's room to eat their meal with supervision. Resident #7 should be supervised with meals, and they were not aware they ate lunch alone in their room on 7/16/2024. This should not have happened. They and the licensed practical nurses were responsible to make sure residents who required supervision during meals were supervised. Speech therapy directed the recommendations for meals and updated the care plan. During an interview on 7/22/2024 at 11:16 AM Speech and Language Pathologist #6 stated any resident on an altered consistency diet should be supervised with meals. Resident #7 was a line-of-sight supervision with meals, and they needed cueing for attention to eating. They should either eat in the dining room or have a staff member in their room with them for meals. Resident #7 had dysphagia and should be monitored for coughing after eating and it was not appropriate they ate alone in their room. 10NYCRR 415.12(h)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 33421 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure a resident who needed respiratory care was provided such care consistent with professional standards of practice for 1 of 1 resident reviewed (Resident #19). Specifically, Resident #19's bilevel positive airway pressure machine (non-invasive mechanical ventilator that applies pressure to keep airway open when sleeping) was not cleaned per professional standards. Findings include: The facility policy CPAP/BiPAP Support [continuous positive airway pressure/bilevel positive airway pressure] , revised 1/2024, documented specific cleaning instructions were obtained from the manufacturer/supplier. The machine was to be cleaned once a week and as needed. The mask, nasal pillow, and tubing were to be cleaned daily using warm soapy water and allowed to air dry. Resident #19 had diagnoses including respiratory failure, sleep apnea (breathing stops and starts during sleep), and chronic obstructive pulmonary disease (lung disease). The 6/18/2024 Minimum Data Set assessment documented the resident had intact cognition, had functional limitation in both arms, required supervision with most activities of daily living, had shortness of breath when lying flat, and used a non-invasive mechanical ventilator. The 8/2/2023 physician order documented Bilevel Positive Airway Pressure at bedtime and as needed. Bilevel Positive Airway Pressure settings were Expiratory Pressure: 8; Inspiratory Pressure: 16; Fraction of Inspired Oxygen: 30% for respiratory failure with oxygen at 2.5 liters, to be worn every night at bedtime. Change oxygen tubing weekly every Thursday night for infection control. There was no documentation of a cleaning schedule for the device. The 3/21/2024 comprehensive care plan documented the resident had sleep apnea, had a Bilevel Positive Airway Pressure/Continuous Positive Airway Pressure device, pneumonia and was on droplet isolation precautions. Interventions included medications as ordered, personal protective equipment use as indicated, apply Continuous Positive Airway Pressure per orders, observe for poor airway clearance and gas exchange, and maintain/change tubing per protocol. The comprehensive care plan did not include maintenance or cleaning of the device. The 5/16/2024 comprehensive care plan documented the resident had sleep apnea and had a Bilevel Positive Airway Pressure/Continuous Positive Airway Pressure device. Interventions included apply Continuous Positive Airway Pressure device per physician orders, observe for poor airway clearance and gas exchange, provide oxygen per orders, and maintain/change tubing per protocol. The 7/2024 treatment administration record documented: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bilevel Positive Airway Pressure at bedtime and as needed. Bilevel Positive Airway Pressure settings were Expiratory Pressure: 8; Inspiratory Pressure: 16; Fraction of Inspired Oxygen: 30% for respiratory failure with oxygen at 2.5 liters. This was documented as done 17 of 21 days. It was not signed for on 7/1/2024, 7/4/2024, and 7/16/2024. The resident was in the hospital on 7/5/2024 per documentation. - Change filter in Bilevel Positive Airway Pressure every night shift every 30 days. This was not documented as done that month. - There was no documentation to change oxygen tubing weekly every Thursday night for infection control or a cleaning schedule. During an observation on 7/15/2024 at 1:58 PM, the resident's Bilevel/Continuous Positive Airway Pressure (non-invasive mechanical ventilation therapy used to treat sleep apnea) mask was on the floor next to the bed. During an observation on 7/19/2024 at 8:52 AM, Resident #19 was sitting in a wheelchair in their room. The oxygen concentrator and Bilevel/Continuous Positive Airway Pressure were off. The resident stated they used oxygen usually at night and as needed during the day. The resident stated they did most of their care by self. The Bilevel/Continuous Positive Airway Pressure mask and cushion had white and black specs inside them. The mask harness edges were frayed. During an observation on 7/22/24 at 9:58 AM, Resident #19 was lying on top of their bed. The resident stated they removed the Bilevel/Continuous Positive Airway Pressure mask by themself, sometimes it fell on the floor, and they would pick it up and put it on the nightstand. They did not always tell staff when the mask fell . The Bilevel/Continuous Positive Airway Pressure had white surgical tape around the joint where the mask port was inserted into the tubing. The full-face mask and cushion had white and black specks inside. The mask harness had frayed white material showing from the black harness. The resident stated staff cleaned the mask occasionally but did not remember the last time it was cleaned. There was a new mask cushion in the top dresser drawer and a new mask and harness in the top nightstand drawer. During an interview on 7/22/24 at 1:49 PM, Licensed Practical Nurse #8 stated the night shift usually cleaned the Bilevel/Continuous Positive Airway Pressure equipment and changed the tubing and masks. This task should be signed for in the treatment administration record. The record should also document the application and removal of the mask, as there should be a physician order to do so. A registered nurse was responsible for putting the order in the record and care plan for the resident. They were not sure how frequently the mask and tubing should be changed. The resident did not have a physician order for cleaning the equipment. If the equipment was not cleaned regularly, the resident could get a respiratory infection and possibly pneumonia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/24 at 1:53 PM, Registered Nurse Manager #2 stated the resident should have an order for cleaning the Bilevel/Continuous Positive Airway Pressure equipment daily, it should be recorded in the Treatment Administration Record and in the care plan. The resident had no orders for cleaning or changing the mask or tubing. There was an order to change the filter. There were also no directions in the care plan about cleaning or changing the equipment. The reason for cleaning and changing the equipment was to prevent a respiratory infection, including pneumonia, and to maintain optimal ventilation. They did not know when the equipment was last changed. The resident's equipment was observed with the Nurse Manager. The Nurse Manager stated the mask was dirty as it had white and black specks inside and should have been cleaned. The mask and cushion had not been changed in a while as it had tape around the end of the tubing. During an interview on 7/22/2024 at 2:15 PM, Physician #9 stated the Bilevel/Continuous Positive Airway Pressure equipment should be washed and changed per orders and the mask cleaned daily. The mask was usually changed every 3 months and tubing every 6 months. The resident could get an upper respiratory infection if the equipment was not cleansed and changed frequently. The facility should have protocols for this. During an interview on 7/22/2024 at 2:41 PM, the Director of Nursing stated the resident should have an order and care plan for changing and cleaning the Bilevel/Continuous Positive Airway Pressure equipment. The mask should be cleansed daily, and equipment replaced if broken. The mask should not have white and black specks in it as an unclean mask could cause respiratory infections. They were not sure of the frequency for replacing equipment. The resident had a respiratory infection in 2023 and pneumonia in 4/2024. Both could have been caused by an unclean mask. The care plans were initiated by the Unit Managers or the Director of Nursing and could be altered by a registered nurse. They expected staff to follow the care plans and physician orders. The Admission Nurse should have put the initial orders in the record and the Unit Manager should have ensured they were in the record. 10NYCRR 415.12(k)(5)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49448 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure that residents who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) services received such services consistent with professional standards of practice for 1 of 1 resident (Resident #59) reviewed. Specifically, Resident #59 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments including assessment of the dialysis access site. Additionally, there was not consistent ongoing communication and collaboration between the facility and the dialysis center. Findings include: The 10/21/2021 facility Dialysis Service Agreement with the community-based dialysis center documented the care facility agreed to furnish all appropriate medical information including current treatments and medications provided to the resident. The facility policy, Dialysis Communication, last reviewed 1/2024 documented all residents receiving dialysis at an outpatient dialysis center had a communication book created. On the days of dialysis, prior to transport for treatment, the nurse took vital signs, documented relevant labs and pre-dialysis weight into the communication book. An evaluation of the resident's access site was completed, and all findings were documented in the communication book as well as the resident's medical chart. Any relevant events would be documented in the communication book for the dialysis center's review. Abnormal vital signs prior to dialysis were reported to the facility's medical professional. Upon return to the facility the nurse reviewed the dialysis communication book regarding the resident's treatment, labs taken at dialysis, vital signs, and post dialysis weight. The nurse documented information in the medical record. Resident #59 had diagnoses including end stage renal (kidney) disease, dependence on renal dialysis, and hypotension (low blood pressure). The 7/8/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not reject care, and required hemodialysis treatments. The Comprehensive Care Plan initiated 7/2/2024 documented the resident needed dialysis related to end stage renal disease. Interventions included check dressing daily at access site, change dressing only if ordered by the physician, document condition and complications. Monitor for signs of infection such as redness, swelling, warmth, or drainage and document. The Comprehensive Care Plan did not include the type of dialysis access site the resident had. The 7/3/2024 physician order documented the resident was to attend dialysis on Tuesday, Thursday, and Saturday. Pre-dialysis evaluation to be completed every Tuesday, Thursday, and Saturday on the day shift. The 7/8/2024 physician order documented post-dialysis evaluation to be completed every Tuesday, Thursday, and Saturday for post-dialysis on the evening shift. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Records dated 7/13/2024-7/19/2024 documented the resident attended dialysis on 7/13/2024, 7/16/2024 and 7/18/2024. The pre-dialysis evaluation was not documented as completed on 7/13/2024 and the post-dialysis evaluation was not documented as completed on 7/13/2024 and 7/16/2024. There was no documented evidence of pre-dialysis or post-dialysis evaluations from 7/13/2024-7/19/2024. The resident's dialysis communication book included an active medication list from 5/2024 and a laboratory results report from 7/4/2024. Vital signs were documented on 7/13/2024. The communication book did not include documentation if these were pre-dialysis or post-dialysis vital signs, weights, or evaluation of the dialysis access site or a signature for the documentation. There was no documentation related to dialysis evaluation for 7/16/2024 and 7/18/2024. During an observation and interview on 7/15/2024 at 10:02 AM, Resident #59 was sitting up in their bed in their room. They had a right chest dual lumen Permacath (a central dialysis access catheter inserted into a vein) for dialysis, covered with a white dressing that was clean, dry, and intact. They stated they had been on dialysis for the past 3 months and attended on Tuesday, Thursday, and Saturday every week. The facility staff never looked at their dialysis access site. Only the dialysis center staff looked at it and changed the dressing. They did not recall the facility obtaining vital signs or weights before or after dialysis treatments. They stated there was a binder that went with them back and forth from dialysis. During an interview on 7/19/2024 at 11:41 AM, Licensed Practical Nurse #13 stated the dialysis communication book went back and forth to dialysis and included a current list of medications, the past month of reports from the dialysis unit, and pre and post dialysis weights. It was the licensed practical nurse's responsibility that a pre and post dialysis evaluation was charted, and this included the appearance of the dialysis access site and the time of transportation to the dialysis site. The Treatment Administration Record included a sign off that prompted charting the pre and post dialysis evaluations. The active orders from May were not current and there should be current orders in the communication book. It was important the access site was monitored for signs of infection or bleeding. They had cared for Resident #59 this week and did not know why the evaluations were not charted. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/19/2024 at 12:00 PM, Registered Nurse Unit Manager #5 stated there was an electronic evaluation in the resident's medical record for pre and post dialysis. The evaluation included a dialysis access site assessment. Vital signs were documented in the communication log in the communication book. The weights were only done at dialysis and not at the facility. There were no documented evaluations in Resident #59's medical record for this week. There were only vital signs in the communication book for 7/13/24 that were not even complete. They did not know why evaluations and documentation in the communication book were not done. Without documentation, there was no way of knowing if the evaluations were being completed. It was important to monitor vital signs. They were supposed to be notified of any vital signs that were not in normal limits so they could contact the medical provider. It was important to monitor dialysis sites because they were the resident's lifeline. Resident #59 was very sick. Dialysis would not know their current orders because they were from May 2024, and the resident had recently been hospitalized and there were order changes since then. The communication book was intended to be a two-way street for communication between the facility and the dialysis center. They did not know if it was their responsibility to update the communication book. If information was not in the book, it was not communicated to the dialysis center. The dialysis center did not have access to the resident's electronic medical records. During an interview on 7/19/2024 at 1:52 PM, Acting Director of Nursing #3 (from a sister facility, filling in for the Director of Nursing while on leave) stated the dialysis communication book should have current orders for accurate exchange of information for resident safety. The pre and post dialysis evaluations should be completed as staff was expected to follow orders and document appropriately. Without documentation, it would not be known if the evaluations were being completed. It was important to monitor vital signs and the dialysis access site for possible changes in condition or adverse effects such as signs of infection or bleeding. During an interview on 7/22/2024 at 1:12 PM the Director of Nursing stated nursing staff was expected to document pre and post dialysis evaluations for safety. Resident #59 was on dialysis. Without proper evaluations the resident could become hypotensive or retain fluid. Their access site should be monitored for bleeding, signs of infection, drainage, and odor. 10NYCRR 415.12(k)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 33421 49448 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and include the expiration date when applicable for 3 of 3 medication carts (Unit 1- medication cart 1, Unit 2- medication cart 1, and Unit 2- medication cart 2) reviewed. Specifically, - Unit 1- medication cart 1 contained 7 medications that were not labeled with resident specific identifiers or with opened/ discard dates; 7 resident specific multidose insulin (treats blood sugar) pens, 1 multidose eye drop, and 1 multidose eye ointment that were not labeled with opened and discard dates; and 1 unopened insulin pen that was not stored appropriately in the refrigerator. - Unit 2- medication cart 1 contained 1 multidose insulin pen that was not labeled with resident specific information and 1 resident specific multidose insulin pen that was not labeled with an opened or discard date. - Unit 2- medication cart 2 contained stock medications that were expired. Findings include: The facility policy, Administering Medications, revised 1/2023 documented the expiration/ beyond use date on the medication label must be checked prior to administering. When a multi-dose container was opened, the date opened was recorded on the container. Insulin pens containing multiple doses were for single-resident use only. Insulin pens should be clearly labeled with the resident's name and other identifying information. Prior to administering insulin, the nurse verified the correct pen was being used. Each nurse's station had a current medication reference. The facility policy, Insulin Administration, reviewed 1/2024 documented prior to insulin being administered, the expiration date was checked. If a new vial was opened, the expiration date and time was recorded on the vial. Manufacturer recommendations for expiration after opened were followed. The facility policy, Storage of Medications, reviewed 1/2024 documented the facility stored all drugs and biologicals in a safe, secure, and orderly manner. Drug containers that had missing, incomplete, improper, or incorrect labels should be returned to the pharmacy for proper labeling before storing. The facility should not use discontinued, outdated, or deteriorated drugs or biologicals. Any such drugs should be returned to the pharmacy or destroyed. Medications requiring refrigeration must be stored in the refrigerator in the drug room. The nursing staff was responsible that medication storage was maintained in a safe manner. (continued on next page)

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Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/16/2024 at 1:01 PM of the Unit 2- medication cart 2 and interview with Licensed Practical Nurse #8, there was an opened stock container of loratadine (treats allergy symptoms) 10 milligram tablets labeled with an expiration date of 5/2024. Licensed Practical Nurse #8 stated the medication was expired and Assistant Director of Nursing checked all the medication carts a week or two ago for expired medications. They were not sure if they administered that medication to any residents today. During a medication cart review of the Unit 1- medication cart 1 on 7/16/2024 at 1:04 PM with Licensed Practical Nurse #18, the following medications were observed: -4 budesonide inhalation suspension 0.5 milligram/ 2 milliliter (used to treat wheezing and shortness of breath associated with asthma) vials in an unboxed opened bag, that were not labeled with resident specific information and/or opened/ discard dates. - 1 opened vial of Haldol 5 milligram/milliliter (antipsychotic), that was not labeled with resident specific information and/or opened/ discard dates. - 1 unopened hydroxyzine 25 milligrams/milliliter (antihistamine) vial, that was not labeled with resident specific information and/or opened/ discard dates. - 1 opened insulin Aspart (short-acting) multidose vial that was not labeled with resident specific information and/or opened/ discard dates. - 2 multidose insulin pens (Basaglar, long-acting) and Lantus (long-acting) for Resident #55 that were not labeled with opened or discard dates. - 1 multidose Lantus insulin pen for Resident #7 that was not labeled with opened or discard dates. - 2 multidose insulin pens (glargine, long-acting and Aspart) for Resident #23 that were not labeled with opened or discard dates. - 1 multidose Basaglar insulin pen for Resident #4 that was not labeled with opened or discard dates. - 1 multidose insulin glargine pen for Resident #61 that was not labeled with opened or discard dates. - Atropine eye drops 1% and erythromycin (antibiotic) eye ointment for Resident #7 that were not labeled with opened or discard dates. - 1 unopened multidose Admelog (short-acting) insulin pen for Resident #55 that was not refrigerated until opened as required. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	None of the insulin pens in the cart were labeled or stored appropriately. Licensed Practical Nurse #18 stated insulin pens should be stored in the refrigerator until opened. Without an opened date, an expiration date would be unknown. Expired medications may not be as effective and could lead to uncontrolled blood sugars or the medications may not effectively treat the intended purpose. Whoever opened the medication was responsible to ensure it was dated as opened. If they found a medication that was not dated, it should be discarded. They stated they did administer the undated Lantus insulin pen to Resident #7 today and they did not check for a date on the pen prior to the medication being administered but they should have. They stated without resident identifiers they would not know who the medication was intended for. Medications should be labeled to ensure the right medication was going to the right resident. If a medication was not labeled when opened, they would not know if they were giving expired medications. They were not sure how long eye drops were good for after opened. During a medication cart review of the Unit 2- medication cart 1 on 7/16/2024 at 1:26 PM with Licensed Practical Nurse #1, there was one multidose Humalog (short-acting) insulin pen that was not labeled with resident specific information or an opened or discard date and one multidose insulin Glargine pen for Resident #15 that was not labeled with an opened or discard date. Licensed Practical Nurse #1 stated they would not use the medication because they did not know who it was intended for or if it was expired. Insulin was good for 30 days after opened. These medications were considered expired as there were no opened dates. They stated the Assistant Director of Nursing checked all the medication carts a couple of weeks ago for expiration dates. All nurses were supposed to check the individual medications for expiration dates prior to any medication being administered. The nurse that opened the insulin pen was responsible it was labeled with an opened date. During an interview on 7/16/2024 at 1:40 PM Registered Nurse Unit Manager #5 stated once an insulin pen was removed from the refrigerator the nurse should make sure it was labeled with a resident name and document the opened date on the pen. It was important it was labeled as opened because insulin was only good for a certain amount of time and without an opened date it would be unknown if it was expired. They did not know how long insulin was good for after opened. If a nurse pulled a pen from the cart that was not dated, it should be discarded. If a resident received expired insulin, it may not be effective in treating their blood sugar. Unopened insulin pens were kept in the refrigerator to keep them viable/ effective. Eye drops were also dated as opened as they were only good for a certain amount of time and could possibly not effectively treat their intended use if administered after they were expired. Prior to medication administration, the nurses should make sure the expiration date was checked. The Assistant Director of Nursing did a medication cart audit a couple of weeks ago and they were surprised these medications were not caught as expired/ undated. There was not currently an educator for the facility, and they were unsure when staff was educated last on medication storage. During an interview on 7/16/2024 at 1:43 PM Registered Nurse Unit Manager #2 stated they were not sure how long insulin was good for after opened. They did not know who checked for expiration dates, but each nurse was supposed to check for expiration dates prior to medications being administered. They were not sure where overstock medications were kept. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/2024 at 1:51 PM the Assistant Director of Nursing stated nurses were expected to check expiration dates every time they administered a medication. The night shift nurses were supposed to go through the medication carts, medication rooms, and medication refrigerators for expiration dates weekly. They were not sure if these checks were documented anywhere. Insulin pens were good for 30 days and the nurse that opened the pen was responsible to make sure the pen was dated when opened. Every insulin pen should have resident identifiers to prevent cross contamination as the pens were resident specific could not be shared. They had done a medication cart audit a couple of weeks ago and the stock loratadine pills were expired and must have been an oversight and should not have been in the cart. They were unsure when education on medication storage was last provided. 10NYCRR 415.18(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33421 43754 49448 Based on observation and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure each resident received and the facility provided food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 test tray meals (the 7/16/2024 lunch meal and the 7/18/2024 lunch meal) reviewed; and for 12 of 12 anonymous residents present at the Resident Council meeting. Specifically, the 7/16/2024 and 7/18/2024 lunch meals were not served at palatable and appetizing temperatures and were not flavorful; the 7/18/2024 lunch meal test tray contained a foreign substance and had a missing item. Additionally, 12 of 12 anonymous residents at the Resident Council meeting stated the food was not flavorful, was not served at appetizing and palatable temperatures, and often had missing items; and Resident #15 stated the food was often flavorless. Findings include: The facility policy, The Dining Experience, reviewed 1/2024 documented the dining experience enhanced each individual's quality of life by providing nourishing, palatable, and attractive meals that met the individual's daily nutritional needs and food and beverage preferences and were served at safe and appetizing temperatures. The facility policy, Accuracy and Quality of Tray Line Service, last reviewed 1/2024 documented all meals were checked for accuracy by the food and nutrition services staff and by the service staff prior to the meal being served to the individual. During a Resident Council group interview on 7/15/2024 at 1:57 PM, 12 anonymous residents stated the food did not taste good, the hot foods were not always hot, the cold foods were not always cold, and they often were missing food items from their meal trays. During an interview on 7/15/2024 at 3:36 PM, Resident #15 stated they only ate mashed potatoes and gravy because the food was tasteless. During a lunch meal observation on 7/16/2024 at 12:29 PM, Resident #59 was served their lunch meal tray (the resident was not present in the facility for the lunch meal). Their lunch tray was tested . The cheesy beef and rice casserole temperature was measured at 126 degrees Fahrenheit, the black beans were 112 degrees Fahrenheit, the fruit mix was 68 degrees Fahrenheit, the milk was 62 degrees Fahrenheit, and the yogurt was 59 degrees Fahrenheit. The milk tasted unpleasantly warm, the black beans were bland, and the cheesy beef and rice casserole was bland and tasted like plain rice with unseasoned ground beef and melted cheddar cheese on top. Registered Nurse Unit Manager #5 was present for the temperature readings of the lunch tray. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a lunch meal observation on 7/18/2024 at 12:20 PM, Resident #68 was served their lunch meal tray. The tray was tested , and a replacement tray was ordered for the resident. The hamburger temperature was measured at 117 degrees Fahrenheit, the carrots were 119 degrees Fahrenheit, the coffee was 156 degrees Fahrenheit, and the peaches were 60 degrees Fahrenheit. The French fries were mushy and contained bits of dark brown paper; the carrots had large, blackened pieces mixed in; and the hamburger tasted bland. The meal tray did not include the apple slices that were listed on the ticket. Certified Nurse Aide #7 was present for the temperature readings of the lunch tray. The Director of Clinical Compliance approached while the meal tray was tested and could not identify the blackened substances in the carrots or dark brown substance in the French fries. They stated that was not acceptable for service. During an interview on 7/18/2024 at 12:46 PM the Acting Food Service Director stated the black substance on the carrots and Fries was the parchment paper they were cooked on. The parchment paper should not have been in the food, and it should not have been served that way. The menu had changed that morning and the apples were not removed from the meal ticket. They had switched to hamburgers because the planned pork was not thawed. During an interview on 7/18/2024 at 1:53 PM Dietary Supervisor #32 stated they changed the menu, and the change was directed by the former Food Service Director. The meal was planned as herb rubbed pork and was changed to hamburgers, French fries, and carrots. The apple slices appeared to have been added by the registered dietitian on 7/11/2024 and did not know why the registered dietitian would add a menu item that was not available. During an interview on 7/18/2024 at 2:02 PM Registered Dietitian #33 stated they added the apples to Resident #68's meal on 7/11/2024 per the resident's preference because they did well with finger foods. Available foods depended on what was delivered to the facility, and they were not aware of what came on the truck on a weekly basis. If apples were not available an appropriate substitute should have been on the plate. The apples had been consistently on the meal ticket since 7/11/2024 and they should have been notified, and a substitution should be made, if they apples were not available. They did not do test trays. The parchment paper mixed with the food was a choking hazard. During a follow up interview on 7/18/2024 at 2:44 PM Dietary Supervisor #32 stated they did test trays. When doing a test tray, they noted the time it arrived on the unit, the time meals started to be passed, and the time the last meal was passed. They measured and recorded the temperatures of all items on the tray and obtained the temperature measurements from the cooks. Hot items were supposed to be over 135 degrees Fahrenheit and cold foods were supposed to be under 55 degrees Fahrenheit except for milk that was supposed to be under 45 degrees Fahrenheit. Canned fruits and yogurt should also be served cold. The temperatures they measured were milk at 62 degrees Fahrenheit, fruit cup at 68 degrees Fahrenheit, yogurt at 59 degrees Fahrenheit, chilled peaches at 60 degrees Fahrenheit. None of these temperatures were acceptable. Everything had just come out of the cooler, and they did not know why they were warm. 10NYCRR 415.14(d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, hot food was improperly cooled, the mechanical dishwasher was not functioning as designed, and outdated foods were present in the walk-in cooler. Findings include: The facility policy, Food Safety and Sanitation dated as reviewed 1/2024, documented leftovers were used within 72 hours (or discarded). The facility policy, Cleaning Dishes/Dish Machine, dated as reviewed 1/2023 documented the dish machine would be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing. The facility Cook/Time Temperature Cooling Log revised 12/1/2017, documented items had 2 hours to decrease from 135 degrees Fahrenheit to 70 degrees Fahrenheit and 4 hours to decrease from 70 degrees Fahrenheit to 41 degrees Fahrenheit. Improper Cooling: During an observation on 7/16/2024 at 11:50 AM a pan of rice labeled 7/16 was on the bottom shelf of the walk-in cooler and its temperature was measured at 123 degrees Fahrenheit. The pan (4-inch deep, 1/4 hotel pan) was covered by plastic wrap. The rice temperature was measured at 1:20 PM at 101 degrees Fahrenheit. During an interview on 7/16/2024 at 1:23 PM, [NAME] #37 stated they made the rice around 10:30 AM that morning. They did not measure the temperature of the rice. They cooked it, wrapped it, labeled it, and placed it in the walk-in cooler. Sometimes they kept leftovers after meal service. They measured the temperature before items went into the cooler, wrapped them, labeled them, and put a note in the menu book to use those items the next time that meal came up. They also had a cooling log they recorded for the proteins like beef, pork, and turkey which were often cooked and cooled the day before they were served. The Cook/Time Temperature Cooling Log documented 17 food items from 3/6/2024 to 7/14/2024 were recorded. All items listed had incomplete records similar to the following; on 7/13/2024 turkey was 180 degrees Fahrenheit at 3:30 PM, at 5:00 PM it was 148 degrees Fahrenheit. That was the end of the documentation of cooling for the turkey. A pork loin on 7/14/2024 was documented at 2:30 PM as 181 degrees Fahrenheit and at 3:00 PM as 150 degrees Fahrenheit. That was the end of the documentation when the log was reviewed on 7/16/2024 at 12:05 PM. The log provided by the facility on 7/22/2024 had additional entries under the 2 hour column of 71, and 4 hour column of 41. The facility did not provide an explanation for the additional entries. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/16/2024 at 1:41 PM, the Temporary Food Service Director stated they kept certain items from one meal to the next, but not much required cooling, just the meats. They only had a census of 67 people so not much was cooked ahead of time. If it was it must be cooled properly. After two hours the properly cooled food must be measured at or below 75 degrees Fahrenheit, and again after another 4 hours it must be down to 41 degrees Fahrenheit. During an interview and observation on 7/16/2024 at 1:48 PM, the pan of rice on the bottom shelf of the walk-in cooler was measured at 99 degrees Fahrenheit. The Temporary Food Service Director stated it was not cooled properly and it had to go in the garbage. During an observation on 7/18/2024 at 1:35 PM, a 6-inch deep 1/4 hotel pan of scrambled eggs located on the bottom shelf of the walk-in cooler was measured at 63 degrees Fahrenheit. The pan was covered with plastic wrap and labeled, 7/18 use by 7/19. At 2:57 PM the eggs were measured at 58 degrees Fahrenheit and at 4:42 PM at 54 degrees Fahrenheit. During an interview on 7/18/2024 at 4:42 PM, the Regional Director of Operations stated they were not sure what time the eggs were made that day. The eggs were located on the bottom shelf where staff had placed leftovers, and the eggs had probably been placed there after breakfast around 10:00 AM that morning because they were beside a pan of breakfast sausage that only contained a few sausage links. The Regional Director of Operations stated the eggs were not cooled properly and they did not have documentation on the cooling process for those eggs, so they needed to be discarded. Improper Dishwashing: The mechanical dishwasher's specifications documented the required wash temperature was 150 degrees Fahrenheit and the final rinse temperature was 180 degrees Fahrenheit. The facility's dish machine washing log documented the temperatures measured in July 2024 were recorded three times a day for wash (150-165 degrees Fahrenheit), final rinse (120/120 degrees Fahrenheit), and chlorine sanitizer (50 parts per million). The final rinse ranged from 115 to 179 degrees Fahrenheit. The wash temperatures on 7/4/2024, 7/5/2024, 7/6/2024, 7/7/2024, 7/13/2024, and 7/14/2024 were documented below 150 degrees Fahrenheit. The chlorine sanitizer was documented three times each day in a range of 350 to 400 parts per million. During an observation on 7/16/2024 at 11:44 AM, the mechanical dishwasher wash temperatures were observed and measured at 153 degrees Fahrenheit. The final rinse digital display read 107 to 108 degrees Fahrenheit. The surveyor used their probe thermometer in the side of the unit and the temperature started to drop as it switched from wash to rinse, at the end of the cycle the temperature measured was down to 134 degrees Fahrenheit. During an interview on 7/18/2024 at 12:54 PM, the Regional Director of Operations stated the dishwasher was a high temperature machine and was checked 3 times a day around the end of each meal service which was recorded on a log sheet. They were not aware of any issues with the dishwasher. During a follow up interview at 1:36 PM, they stated the machine was down recently and operated as low temperature sanitization. On 7/3/2024 the part was replaced because it was sporadically maintaining temperature. They stated the Temporary Food Service Director met with staff regarding the low temperature final rinse and they opted to keep that in there because of the inconsistent temperatures. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 7/18/2044 at 1:43 PM, the Regional Director of Operations attempted to check the level of chlorine sanitizer in the final rinse, but it was not registering, air could be seen in the line and the chlorine solution was not reaching the machine. The facility's dish machine ware washing log documented the morning temperatures and sanitization level were recorded by Dietary Aide #36. During an interview and observation on 7/18/2024 at 1:44 PM, Dietary Aide #36 stated they checked the temperature and the sanitizer by reading the digital display below the machine for the temperatures and using the test strips that were located with the clipboard that contained the log. They stated if it was not within range, they would let somebody know and hopefully maintenance would come and figure it out. Dietary Aide #36 identified that they had been using the quaternary test strips to measure the level of chlorine sanitization. During an observation on 7/18/2024 at 4:44 PM the mechanical dishwasher chlorine sanitization was measured at 10 parts per million. During an interview on 7/18/2024 at 5:03 PM, the Maintenance Director stated the mechanical dishwasher was supposed to be a high temperature machine that the facility owned and maintained. They stated the heating element had been broken on the machine for longer than they had been at the facility which was about a year. The previous Director dealt with that and added the chemical sanitizer, but when they took over as Director about three months ago, they were able to get the part to repair the machine on 7/3/2024 for which they provided email documentation. An email dated 6/28/2024 documented the Maintenance Director had emailed corporate asking to purchase a new heating element which was needed to help with the sanitization of the dishware. The facility's dish machine ware washing log documented one issue on 6/12/2024 for breakfast and lunch, machine down - use paper was recorded. April, May, and June were provided and documented that acceptable temperatures were measured three times daily. No documentation of chemical sanitization was recorded. Outdated food in the walk-in cooler: During an observation on 7/16/2024 at 11:50 AM the bottom shelf of the walk-in contained a pan (half hotel, 4-inch deep) of chicken [NAME] covered with plastic wrap and labeled 7/11. A bag of cooked potatoes (commercial product) was opened and wrapped with plastic wrap that was dated 7/3. During an interview on 7/16/2024 at 1:23 PM, [NAME] #37 stated they did not have a specific person who reviewed the contents of the coolers. All staff looked for anything older than 3-4 days. What was handwritten was when it was opened. 7/3 for the raw potato, that was still good, but if it was cooked then it would have to be removed within 3 days. The pan of chicken [NAME] on the bottom shelf labeled 7/11 was something that had to be discarded. They stated that was from lunch on 7/11 and they were not sure why it was saved. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/16/2024 at 1:41 PM, the Temporary Food Service Director stated they kept certain things from one meal to the next, but nothing was kept beyond 3 days. They stated the chicken [NAME] from 7/11 or the bag of cooked potatoes that was labeled 7/3 should not have been in the cooler. They checked the cooler the previous day and must have missed those outdated items. 10NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448 Based on observation, record review, and interview during the recertification survey conducted 7/15/2024-7/22/2024, the facility did not establish and 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 for 1 of 1 resident (Resident #59) reviewed. Specifically, staff was observed not wearing the required personal protective equipment in Resident #59's room who was on transmission-based precautions. Findings include: The undated facility policy. Isolation-Categories of Transmission-Based Precautions, documented transmission-based precautions were additional measures that protected staff, visitors, and other residents from becoming infected. When a resident was placed on transmission-based precautions, appropriate notification was placed on the room entrance door, so personnel and visitors were aware of the need for the type of precaution. The signage informed staff of the type of precautions, instructions for personal protective equipment and/ or instructions to see a nurse before the room was entered. Contact precautions were implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with the environment surfaces or resident-care items in the resident's environment. Staff and visitors wore gloves and disposable gowns when entering the resident's room, and gloves and gown were removed, and hand hygiene was performed before leaving the room. Staff avoided touching potentially contaminated environmental surfaces or items in the resident's room after gloves and gown were removed. Resident #59 had diagnoses including recurrent enterocolitis (inflammation throughout the intestines) due to clostridium difficile (a highly contagious bacteria that can cause diarrhea), end stage renal (kidney) disease, and sepsis (a serious condition in which the body responds improperly to an infection). The 7/8/2024 Minimum Data Set assessment dated [DATE] documented the resident was cognitively intact, was dependent for toileting, was frequently incontinent of bowel, and did not have any infections. The 7/1/2024 hospital discharge summary documented the principal discharge diagnosis was clostridium difficile colitis. The 7/2/2024 Physician #24 progress note documented a call was received from nursing staff the resident was readmitted back to the facility. The resident had a new medication fidaxomicin for clostridium difficile. The nurse was advised to follow protocols for clostridium difficile precautions. The 7/2/2024 physician order documented fidaxomicin 200 milligram oral tablet twice daily for clostridium difficile. There were no physician orders for transmission-based precautions. The comprehensive care plan initiated on 7/2/2024 did not document the resident was on transmission-based precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335233	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/15/2024 at 2:49 PM, Resident #59 was sitting up in bed in their room, there was a contact precaution sign next to the door frame. They stated they were on precautions for clostridium difficile which they had when they were in the hospital. The brown signage on the right hand side of the door frame outside of the room documented contact/ enteric precautions- everyone must wash hands with sanitizer upon entering the room and wash with soap and water when exiting the room. Gown and gloves must be on when entering the room. Doctors and staff must use patient dedicated or disposable equipment, clean and disinfect shared equipment when leaving the room. During an observation on 7/16/2024 at 9:09 AM, Certified Nurse Aide #25 was in Resident #59's room changing the bed linens (the resident was not in the room). They were not wearing gloves or a gown. Certified Nurse Aide #25 exited the room at 9:13 AM without performing hand hygiene, and immediately went to the room next door and changed the bed linens. During an observation on 7/18/2024 at 9:30 AM, Registered Nurse Unit Manager #5 exited Resident #59's room without gown or gloves, holding a personal blanket and oxygen tubing from the resident's room. They stated the resident was going to dialysis. During an observation on 7/19/2024 at 12:31 PM, Licensed Practical Nurse #13 entered the resident's room with the resident's lunch tray and exited the room with the lunch tray lid. They did not perform hand hygiene, placed the lid on top of the warming cart in the hallway by the nursing station, picked up a pen, documented meal consumption on another resident's ticket, picked up a different meal tray and placed it in the cart. Licensed Practical Nurse #13 then entered the dining room to assist other residents and did not perform hand hygiene. During an interview on 7/19/2024 at 1:28 PM Licensed Practical Nurse #13 stated prior to entering Resident #59's room they performed hand hygiene and put on gloves and a gown. They stated the resident was on neutropenic precautions (precautions used for residents who are immunocompromised) for end stage renal disease. They stated the resident was on medications for clostridium difficile, but the precautions were not for that, they were to protect the resident from germs that could cause death. During an interview on 7/19/2024 at 1:37 PM Registered Nurse Unit Manager #5 stated gowns and gloves needed to be worn any time Resident #59's room was entered as they were on precautions for clostridium difficile. They should not have given the resident their personal blanket to take to dialysis because it could be contaminated. The certified nurse aides should not be changing bed linens without appropriate personal protective equipment and should not have left Resident #59s room to enter another room as they were carrying the germs from room to room. They did not know why there was no order for the resident to be on contact precautions. They were responsible for placing those orders. They expected the nurses to know why a resident was on precautions and if they did not know, they should ask. During an interview on 7/19/2024 at 1:47 PM Certified Nurse Aide #25 stated Resident #59 was on precautions for clostridium difficile and they put a gown and gloves on every time they went in the resident's room even if the resident was not in the room. They stated they did not change the resident's bed linens on 7/16/2024 and was picking up the resident's things. They did not wear personal protective equipment, but they should have so they did not contaminate other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/2024 at 1:12 PM the Director of Nursing/ Infection Preventionist stated staff were expected to follow the signage outside the door of an isolation room. There was never a time it was appropriate to enter an isolation room without the required personal protective equipment. Resident #59 was on precautions for clostridium difficile. The nurse should have given the resident a clean blanket for dialysis and not their personal blanket. The personal blanket could have been contaminated. Personal protective equipment and hand hygiene were important to prevent the spread of infection. 10NYCRR 415.19(a)(2)