STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335269	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wartburg Home	1 Wartburg Place Mount Vernon, NY 10552

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation and interviews conducted during the recertification survey from 7/22/25 to 7/28/25, the facility did not ensure food was stored, prepared, and distributed in sanitary conditions in accordance with professional standards for food service safety. Specifically, there were unlabeled and undated food items in the kitchen, storeroom, and unit pantry, there was expired foods in the kitchen, storeroom, and unit pantry, there was a cell phone on the food prep area, dietary staff did not wear proper hair and beard restraints, there were boxes stored on the floor, there was personal staff item in kitchen food prep area and there were poor sanitary conditions in unit pantries. Findings include: The facility policy Food and Supply Storage, last revised 1/2025 included documentation that food past the use by date or expiration date should be discarded; opened packages should be covered, labeled and dated; and items should be stored at least 6' above the floor and 18' below sprinklers. The facility policy Uniform Dress Code, last revised 1/2025 included documentation that associates working with food are expected to wear the approved hair restraint when on duty regardless of length or presence of hair and to restrain all facial hair with a beard net. The facility policy Use and Storage of Food Brought to Residents from the Outside last revised 1/2025 included documentation that care is taken ensure food is handled properly for safe and sanitary storage and consumption. The facility policy Area and Equipment Cleaning last revised 1/2025 included documentation of assignment of daily cleaning responsibilities of each position workflow. During kitchen observation and interview conducted on 7/22/25 at 9:35 AM, the following items were observed: in the kitchen there was undated roasted garlic Caesar dressing, undated swiss cheese, sliced pork and deli ham with an expiration date of 7/21/25, undated parmesan cheese (block) with visible mold, container of liquid, labeled as salad, dated 7/6/25 with no expiration date (the Food Service Director stated the item was salad dressing) and an undated container of chopped garlic. In the freezer there was undated lasagna with no identifying label, and peach cobbler with an expiration date of 7/12/25. In dry storage there was Thick- it in an unsealed plastic bag, and raisins with a 7/12/25 expiration date. In the food prep area, there were approximately 10 slices of cooked bacon on a paper plate, wrapped in plastic, unlabeled/undated and unknown food in a 1/3 pan covered in plastic, unlabeled, and undated (the Food Service Director stated they were unable to identify the food). In the emergency food supply, there was 1 case of dry milk powder with a 3/6/23 expiration date, Hershey's Chocolate Syrup with a 7/2024 expiration date, and 16 five-gallon bottles of water with a 12/31/23 expiration date. On the floor there were four boxes with a delivery date of 6/3/25, a large bucket of dish detergent, and chemicals on the floor under the shelving. The Food Service Director stated the chemicals had been there since before 11/2024. There were 13 boxes stacked less than 6 from the ceiling. During an interview at this time, the Food Service Director stated a storeroom diet aide works twice a week to rotate stock, label, date, and dispose of expired items, and they should have removed expired food and water and moved boxes off the floor and away from the ceiling. During observation on 7/22/25 at 11:06 AM, a personal cell phone was observed on the prep counter. At that time, the Food Service Director stated they did not know who the cell phone belonged to and that it should not have been in the food prep area, Dietary [NAME] #5 and Dietary Aide #14 stated it was not their cell phone. Dietary (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335269	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wartburg Home	1 Wartburg Place Mount Vernon, NY 10552

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[NAME] #5 was observed with a beard approximately half an inch long and not wearing a beard restraint. Dietary Aide #14 was observed not wearing a hair net. Both stated they had just arrived in the kitchen and did not put on them on yet. Dietary [NAME] #5 stated their beard wasn't long enough to require a hair restraint. During an observation of Unit 2 North pantry and interview on 7/24/2025 at 11:56 AM, there was a slice of toast on the floor between the refrigerator cabinet and the half wall and a 2x 2 puddle of water that had been walked through and tracked across the floor located in the middle of the pantry floor. Dietary Aide #7 stated the housekeeping department cleans the pantries. Further observation of the items in the refrigerator included an undated peanut butter sandwich, and a resident's person lunch bag dated 7/11/25 containing an expired yogurt dated 7/11/25. Registered Nurse Assistant Unit Manager #4 stated items are dated by nursing staff on the date they are received and should be disposed of after three days by the dietary staff. During an interview with the Food Service Director on 7/24/2025 at 12:08 PM, they stated the dietary staff are responsible for sweeping the unit pantry floors and housekeeping staff are responsible for mopping the unit pantry floors. They stated it is the dietary staff responsibility to dispose of expired food items in the unit pantry refrigerators. During an interview on 7/24/2025 at 2:12 PM, the Interim Director of Environmental Services stated housekeeping staff are not responsible for providing cleaning of the unit pantries. They stated that dietary staff is responsible for cleaning all equipment, floors and refrigerators in the unit pantries. During an interview on 7/25/2025 at 12:28 PM, the Administrator stated the cleaning of unit pantries is the responsibility of the dietary staff which includes floors, refrigerators, microwaves, counters, and cabinets. There is a Duty Roster that is posted for each dietary staff to know their responsibilities. 10 NYCRR 415.14(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335269	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wartburg Home	1 Wartburg Place Mount Vernon, NY 10552

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and interviews during the recertification survey from 7/22/25 to 7/28/25, the facility did not ensure that essential kitchen equipment was maintained in safe operating condition. Specifically, dishwashers in all four-unit pantries were broken, Unit 1 South pantry food warmer, tall standing freezer, and steam table were broken, and the main kitchen dish machine did not reach proper temperature for sanitization in wash (150-165 degrees), rinse, or final rinse (180 degrees) modes. The findings are: During an observation of the Unit 1 South pantry on 7/24/25 at 12:48 PM, a puddle of water was observed by the right front leg of the food warmer and a towel was observed inside the bottom of the upper door frame. Dietary Aide #8 stated the food warmer was broken and leaking water. They also stated the steam table was not working and they were using the hot box to keep food warm, the tall freezer was broken, and the dishwasher was broken. They stated they had verbally told the supervisor about the broken equipment weeks ago, which was the procedure they used to inform the supervisor. There was no documented evidence of communication regarding repairs for the pantries on the units. There was no documented evidence of work orders related to the broken equipment in the pantries on the units. During an interview on 7/25/25 at 11:46 AM, the Food Service Director stated they were aware of the broken equipment on the units. They stated some equipment was broken before they were employed and they had decided not to send repair requests for those items. They stated the procedure for broken unit dishwashers was to send the dishes to the main dish machine in the kitchen for washing. The Food Service Director stated they were aware of a broken refrigerator on a unit but had decided not to repair because there was other refrigeration available. They stated the broken steamtable on Unit 1 South had been evaluated for repair by an outside company with proof of estimate on 6/12/25, but the Food Service Director stated they did not feel it was a priority to repair. During an interview on 7/25/25 at 12:28 PM, the Administrator stated they were not made aware of any broken equipment in the pantries until the evening of 7/23/25 when they were informed of the broken steamtable in the Unit 1 South pantry. They stated there are regular scheduled environmental rounds to identify equipment that would need repaired. They stated if repairs cannot be done onsite, an outside company should be consulted for a proposal. During an interview on 7/28/25 at 12:00 PM, Dietary Aide #11 confirmed the procedure for reporting broken equipment is to verbally report to dietary supervisor. During an observation of the main kitchen dish machine with the Food Service Director on 7/25/25 at 1:17 PM the wash cycle displayed temperature of 124 degrees, rinse cycle displayed E and final rinse cycle displayed temperature of 94 degrees. During that time, the Food Service Director stated they were unable to explain what the E on the rinse cycle was referring to, and why the temperatures were below 150-165 degrees for wash and 180 degrees for final rinse cycle. They stated they will contact the Director of Facilities for assessment and repair. During an interview on 7/28/25 at 8:59 AM, the Food Service Director stated the main kitchen dish machine is out of order due to a computer board malfunction as of 7/25/25 afternoon and the facility had been using paper products for dining all weekend. 10 NYCRR 415.5(e)(1)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335269	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wartburg Home	1 Wartburg Place Mount Vernon, NY 10552

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, record review and interviews during the recertification survey from 7/22/25-7/28/25, the facility did not ensure that each resident received the proper respiratory treatment and care consistent with professional standards of practice for one of one resident (Resident #7) reviewed for respiratory care. Specifically, Resident #7 was receiving oxygen via nasal canula tubing which was observed in the resident's mouth instead of in the resident's nostrils.The findings are:The Policy and Procedure titled Respiratory Care last revised 6/25/2021, documented each resident's respiratory function shall be maintained and optimized to the fullest extent possible. Nurses and certified nurse aides were responsible to monitor nasal cannula, BIPAP, CPAP (or any other respiratory device) placement and condition each shift.Resident #7 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, heart failure, and non-Alzheimer's dementia. The 7/3/25 Physician's Orders documented continuous oxygen at 2 liters per minute via nasal canula.The 7/14/25 Minimum Data Set (resident assessment tool) documented Resident #7 had severely impaired cognition, was dependent on staff with all functional abilities and had shortness of breath when sitting, at rest, or lying flat. During observation on 7/23/25 at 9:43 AM and 12:31 PM Resident #7 was in their bed, awake, with the nasal canula prongs observed in the resident's mouth. During an interview on 7/25/25 at 1:17 PM, Certified Nurse Aide #2 stated they provided assistance to Resident #7 with all activities of daily living and stated Resident #7 required total care. Certified Nurse Aide #2 stated they should check for the correct placement of the nasal canula after all cares were provided. Certified Nurse Aide #2 stated they were responsible for monitoring placement of the nasal canula throughout their shift and should report concerns to the nurse. Certified Nurse Aide #2 stated they were not aware that the resident's nasal cannula had been in the resident's mouth. During an interview on 7/25/25 at 1:26 PM, Licensed Practical Nurse #3 stated they were responsible for Resident #7. Licensed Practical Nurse #3 stated they were responsible for monitoring the nasal canula and oxygen administration for all residents on their assignment to ensure oxygen was administered per the physician's orders. They stated they had not noticed the nasal canula had not been inserted into Resident #7's nostrils on 7/23/25. 10 NYCRR 415.12(k) (6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335269	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Wartburg Home	1 Wartburg Place Mount Vernon, NY 10552

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interviews conducted during the 7/22/25-7/28/25 recertification survey, the facility did not ensure that all medications were secured in a locked storage area. Specifically, Symbicort (budesonide-formoterol) aerosol inhaler was observed on Resident #35's room table, not under direct supervision of authorized staff. The findings are:The undated Policy and Procedure titled Storage of Medications documented only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. The undated Policy and Procedure (P&P) titled Self-Administration of Medications documented those residents deemed capable, and who desire to self-administer their medications, will be permitted to do so, after appropriate counseling and with the specific order of the resident's physician.Resident #35 was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease, diabetes mellitus, and heart failure. The 7/15/25 Physician's Order documented Budesonide 0.25mg/2ml suspension for nebulization. Inhale 2 ml (0.25mg) by nebulizer 2 times per day.The Minimum Data Set (resident assessment tool) dated 7/20/25 documented the resident was cognitively intact.During observations on 7/22/25 at 12:24 PM and on 7/23/25 at 12:58 PM, Resident #35 was sitting in their room. Symbicort (Budesonide-formoterol) 80-4.5mcg/ACT Aerosol inhaler was observed on the resident's table. The resident stated the nurse brought them the Symbicort inhaler and stated they could self-administer the medication. The resident stated they did not remember the nurse's name. The resident stated they knew to self-administer the medication. The resident stated that every day, later in the day, the nurse came and picked up the medication. During an interview on 7/25/25 at 9:58 AM Licensed Practical Nurse #3 stated they did not know any residents on the second floor who would be capable and desired to self-administer their medications. The nurse stated the facility had a policy that residents were not allowed to keep their own medications in their rooms. If any residents admitted to the facility brought their own medications, the responsibility of the nurses was to ask the residents to give the medications to the nurse. The nurse would label and keep the medications in the medication cart. Licensed Practical Nurse #3 opened the medication cart and showed Resident #35's medications for respiratory care. The nurse opened the July 2025 Medication Administration Record for Resident #35 and showed the medications the resident was currently taking. At that time, the surveyor showed the nurse the picture of Resident #35's Symbicort inhalation aerosol medication that had been observed on 7/22/25 and 7/23/25. The nurse stated they had not seen that medication before in Resident #35's room. During an interview on 7/25/25 at 10:28 AM, the Director of Nursing stated that residents cannot keep any medications in their rooms. The Director of Nursing stated any resident who believed they were capable and desired to self-administer their medications would be permitted to do so after appropriate assessment/return demonstration, and a physician order was obtained. The Director of Nursing stated currently they did not know any resident in the facility who was allowed to self-administer their medications. They stated that it was the nurse's responsibility to inform residents and ask if they had any medications in their rooms. During an interview on 7/25/25 at 10:46 AM, Registered Nurse # 4 stated they were the admitting nurse for Resident #35. They stated residents cannot have any medications in their room. They stated that they were responsible for asking if the resident had their own medications. Registered Nurse stated they were not aware the resident had their own medications. During an interview on 7/25/25 at 3:28 PM, Certified Nurse Aide #2 stated they helped Resident #35 with personal care during the day. The Certified Nurse Aide stated they did not see any medications in Resident #35's room and was unaware that Resident #35 was taking any medications by themselves. NY CRR 415.18 (e) [1-4]