

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2024
NAME OF PROVIDER OR SUPPLIER Troy Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 49 Marvin Avenue Troy, NY 12180	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413</p> <p>Based on record review and interviews during recertification and abbreviated survey (Case #NY00322407) from 2/05/2024 to 2/12/2024, the facility did not ensure that all alleged violations of abuse, neglect, or mistreatment, including injuries of unknown source, were immediately reported to the State Agency for 1 (Resident #51) of 3 residents reviewed for abuse. Specifically, the facility did not report the allegations of abuse involving Resident #51 to the New York State Department of Health after becoming aware of the allegations on 8/09/2023 at 7:20 AM.</p> <p>This is evidenced by:</p> <p>Resident #51 was admitted to the facility on [DATE] with diagnoses of Atherosclerosis with unspecified peripheral vascular disease, type II Diabetes, and vascular Dementia with other behavioral disturbances. The Minimum Data Set (an assessment tool) dated 12/10/2021 documented that the resident usually could be understood and understood others, and that the resident had severely impaired cognition for daily living decisions.</p> <p>The facility's Policy and Procedure titled Abuse, last revised 2/2019, documented the facility prohibited the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone, including staff, family, friends, or other residents. The Administrator and Director of Nursing would be responsible for investigating and reporting to the appropriate State Agency(s) immediately (no later than 2 hours after allegation/identification of allegation) after identifying the alleged/suspected incident. The policy further defines abuse as the willful infliction of injury or intimidation resulting in physical harm, pain, or mental anguish. The policy describes verbal abuse as oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident.</p> <p>The New York State Department of Health Intake Information form dated 8/21/2023 documented that on 8/09/2023 at 7:20 AM, Resident #51 was potentially verbally abused by a staff member while going through the hallway. This allegation was reported by one of the witnesses to the incident, who immediately reported it to the Administrator and Director of Nursing. No report of the 8/09/2023 incident was made to the New York State Department of Health before 8/21/2023.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The investigation and incident report dated 8/10/2023 documented that the staff housekeeper made derogatory comments to the resident, which the maintenance person also heard. The investigation stated that since the resident did not hear the derogatory comments, the Administrator ruled out verbal abuse. However, two individuals did hear the verbal comment made by the staff. The employee who conducted the verbal abuse on the resident was immediately suspended pending investigation and ultimately brought back and re-educated extensively on Abuse, Neglect, and Misappropriations.</p> <p>An investigation and incident report dated 12/05/2023 documented a resident-to-resident verbal altercation. The investigation documented that Resident #14 took off the leg rest of their wheelchair and tried to hit Resident #51. The incident was witnessed by a Licensed Practical Nurse who observed Resident #14 with the wheelchair leg rest in their hand, threatening to strike Resident #51. The statement made by Resident #14 documents that they tried to hit him with my leg rest. The investigation stated that since Resident #14 did not make contact with Resident #51, the Administrator documented that this ruled out any evidence of abuse. No report of the 12/05/2023 incident was made to the New York State Department of Health before 2/08/2024.</p> <p>During an interview on 2/08/2024 at 9:58 AM, Administrator #1 stated that incidents of verbal threats, physical harm, and residents were incidents of abuse. They further stated that any incident resulting in abuse should be reported to the New York State Department of Health. They stated that depending on the incident and how the potentially abused resident felt would determine whether the incident would be reported to the New York State Department of Health. The facility abuse policy was reviewed with Administrator #1, as Administrator #1 stated that they could not recall it. They stated that verbal abuse was the oral, written, or gestured language that willfully includes disparaging and derogatory terms to the resident. They stated regarding the incident on 12/05/2023, they did not believe it rose to an abuse situation since Resident #14 did not strike Resident #51; the resident did not feel uncomfortable, so Administrator #1 did not report it. Administrator #1 stated the gesture done by Resident #14 constituted potential verbal abuse according to their policy, and should have reported the incident to the New York State Department of Health.</p> <p>During an interview on 2/08/2024 at 11:38 AM, Resident #51 stated that they did not remember either incident.</p> <p>During an interview on 2/12/2024 at 9:43 AM, Director of Nursing #1 stated that they would consider abuse as any physical or verbal altercation, intimidation, or misappropriation of resident belongings done by staff or resident to resident. They stated that all cases of potential abuse should have been reported to the New York State Department of Health within the specific time of reporting. The incidents were reviewed with Director of Nursing #1, and they stated that the facility should have reported the incidents to the State Agency.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805</p> <p>Based on observations, record reviews and interviews conducted during the recertification survey from 2/05/2024 to 2/12/2024, the facility did not ensure the development of comprehensive person-centered care plans - that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs - as identified in the comprehensive assessment for 2 (Resident #s 14 and 327) of 27 residents reviewed for comprehensive care plans. Specifically, (1) for Resident #327, the facility did not ensure a comprehensive care plan was developed to address the use of indwelling urinary catheter; and (2) for Resident #14, the facility did not ensure a comprehensive care plan was developed to address the resident's dental care.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled Care Plans - Comprehensive, dated 10/2019, documented the facility would develop a comprehensive, resident centered care plan for each resident based on the individual needs/problems of each resident.</p> <p>Resident #327</p> <p>The resident was admitted to the facility with the diagnoses of metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities), severe sepsis with septic shock (a serious condition in which the body responds improperly to an infection including possible organ failure), and cirrhosis of the liver (a condition where scar tissue gradually replaces liver tissue). The Minimum Data Set (an assessment tool) dated 2/27/2023 documented the resident could understand and be understood by others and was cognitively intact.</p> <p>A document titled Consultation documented Resident #327 had been seen by an outside provider on 3/01/2023. The outside provider documented that an indwelling urinary catheter had been placed before Resident #327 returned to the facility.</p> <p>A Physician Order dated 3/15/2023 documented urinary catheter care was ordered.</p> <p>The Treatment Administration Record dated 3/2023 documented urinary catheter care was to be provided every shift.</p> <p>The Comprehensive Care Plan did not address the presence or maintenance of an indwelling urinary catheter.</p> <p>During an interview on 2/12/2024 at 11:17 AM, Registered Nurse #1 stated that all the resident's needs would require a comprehensive care plan to address them. Registered Nurse #1 stated they would expect a care plan to address medications and medical devices like an indwelling urinary catheter.</p> <p>During an interview on 2/12/2024 at 11:23 AM, Licensed Practical Nurse #5 stated a care plan should have been initiated as soon as there was a change. They stated they would go to the Director of Nursing or supervisor to initiate a care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/12/2024 at 11:40 AM, Director of Nursing #1 stated that a resident's comprehensive care plan should include and address all parts of a resident's care. They stated this would include an indwelling urinary catheter along with resident needs such as dental care, hearing aids, nutritional interventions. Director of Nursing #1 stated that registered nurses on the unit were responsible for initiating a care plan but if the unit manager was not a registered nurse, they would expect the unit manager to alert a registered nurse on the need for a care plan.</p> <p>48615</p> <p>Resident # 14</p> <p>Resident #14 was admitted to the facility with the diagnoses of Diabetes type 1 and partial limb amputation. The Minimum Data Set, dated dated dated [DATE] documented the resident could understand and be understood by others and was cognitively intact.</p> <p>During an interview on 2/06/2024 at 9:42 AM, Resident #14 was noted to have multiple missing and broken teeth. Resident #14 stated they wanted to see a dentist, but a dentist appointment had not been made.</p> <p>During record review on 2/06/2024 at 11:00 AM, the comprehensive care plans dated 10/19/2023 and 1/25/2024 did not include dental care.</p> <p>During an interview on 2/08/2024 at 11:30 AM, Director of Nursing #1 stated care plans were updated by the Unit Manager.</p> <p>During an interview on 2/08/2024 at 12:00 PM, Registered Nurse #1 stated the care plan would be updated.</p> <p>10 New York Codes, Rules, and Regulations 415.11(c)(1)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, record review and interviews during a recertification survey from 2/05/2024 to 2/12/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain personal hygiene for 3 (Resident #s 2, 32 and 327) of 27 residents reviewed for Activities of Daily Living. Specifically, (A) Resident #s 2 and 32 were not provided assistance with personal hygiene during morning care; (B) Resident #32 did not have a clean change of clothing and Resident # 2 was not provided sufficient extra-large incontinence briefs; (C) Resident #327 was not provided their weekly shower.</p> <p>This is evidenced by:</p> <p>The facility policy Activities of Daily Living Support effective 08/2016 and revised on 10/2019 documented residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p> <p>Resident #2</p> <p>The resident was admitted to the facility with the diagnoses of urinary tract infection, diabetes mellitus type 2, and hypertension. The Minimum Data Set (an assessment tool) dated 11/28/2023 documented the resident could understand and be understood by others; resident was cognitively intact.</p> <p>The Comprehensive Care Plan initiated 9/22/2023 documented the resident required assistance with Activities of Daily Living related to limited mobility, diabetes mellitus, obesity, and inability to complete Activities of Daily Living tasks. Interventions included a total mechanical lift with assistance of 2 or more staff for transfers.</p> <p>The following observations of Resident #2 were made:</p> <ul style="list-style-type: none"> - On 02/05/2024 at 10:40 AM, resident was in bed wearing a hospital gown. - On 02/06/2024 at 11:00 AM, resident was in bed wearing a hospital gown. Both resident and roommate stated they were waiting for Certified Nurse Aide to assist them with morning care. Resident #2 was noted to have left over breakfast on overbed table, face with crumbs and hair was disheveled. - On 02/06/2024 at 11:10 AM, resident turned on call light, staff responded in 13 minutes and told the resident they would be back. - On 02/07/2024 at 10:13 AM, resident was in bed wearing hospital gown and stated they were waiting for assistance to get washed up. <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/06/2024 at 11:15 AM, Resident #2 stated staff only provided care to them once a day if that. Resident #2 stated they waited for a very long time for care. Resident #2 stated Certified Nurse Aides came into their room and took 3 Extra-large incontinence briefs out of their dresser drawer and were later told that there were no briefs for them and could not be changed. Resident #2 further stated they had a foley catheter secondary to urinary incontinence, however, required assistance after soiling incontinence briefs. Resident stated their son brought in a personal supply of incontinence briefs so that they could get changed.</p> <p>During an interview on 2/07/2024 at 10:30 AM, Certified Nurse Aide #1 stated Resident #2 did not like to get up out of bed. They stated they would move to the next resident when resident refused and documented the resident's refusal.</p> <p>During an interview on 2/07/2024 at 11:00 AM, Registered Nurse #1 stated they had no knowledge of Resident #2 not receiving care or shortage of 3 extra-large incontinence briefs.</p> <p>During an interview on 2/07/2024 at 11:30 AM, Director of Nursing #1 stated they had no knowledge of Resident #2 not receiving care or shortage of 3 extra-large incontinence briefs. Director of Nursing #1 stated the Medical Records/Supply Officer ordered and tracked supplies and would be a contact for more information.</p> <p>During an interview on 2/08/2024 at 9:34 AM, the Medical Records/Supply Officer #1 stated Certified Nurse Aides were to come to them and request 3 extra-large incontinence briefs; 3 extra-large briefs were only provided to residents based on their weight. The Supply Officer stated that 3 extra-large briefs were rationed out. Supply Office #1 further stated that otherwise, Certified Nurse Aides would use them on residents who did not require large incontinence briefs; all other sizes were stocked on the units; the 3 extra-large incontinence briefs were locked in a secure location after hours.</p> <p>Resident # 32</p> <p>The resident was admitted to the facility with the diagnoses of osteoarthritis, difficulty walking, chronic obstructive pulmonary disease, weakness, and depression. The Minimum Data Set, dated dated [DATE] documented the resident could understand and be understood by others, and was cognitively intact.</p> <p>The Comprehensive Care Plan initiated 3/17/2017, revised 11/02/2024, documented the resident required assistance with ADLs related to limited mobility, osteoarthritis, chronic left shoulder pain, and inability to complete Activities of Daily Living tasks. Resident required is a partial assist with 1 staff helper. Resident encouraged to use call light for assistance.</p> <p>During an observation on 2/05/2024 at 12:59 PM, South Unit room [ROOM NUMBER] call light remained on for 20 minutes. There were 6 staff in the vicinity of room [ROOM NUMBER] that did not answer light, instead went about other duties.</p> <p>During an observation on 2/07/2024 at 11:11 AM, a resident was sitting at the nurse's station on south unit yelling out repeatedly, please take me to the bathroom, my stomach hurts, I have to poop really bad. Certified Nurse Aide #4 stated to Certified Nurse Aid #5, you know how [they do]. Both Certified Nurse Aids walked away without assisting the resident.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of staffing sheets dated 2/02/2024 - 2/05/2024 documented 4 Certified Nurse Aides and 2-3 Licensed Practical Nurses on 7 AM - 3 PM shift: 3 Certified Nurse Aides and 2-3 Licensed Practical Nurses on 3p-11p shift, and 2 Certified Nurse Aides and 1 Licensed Practical Nurse on 11p-7a shift.</p> <p>Record review of Certified Nurse Aide Accountability shower sheet for the week of 1/26/2024 to 2/06/2024 documented the resident refused shower on 1/26/2024 and 1/30/2024. Resident received shower 2/2/2024 and 2/6/2024.</p> <p>Record review of Grievance dated 7/21/2023 documented resident filed a grievance with facility for help during the night, stating they wait hour and half for assistance.</p> <p>During an interview on 2/05/2024 at 11:45 AM, the resident was observed in their room sitting in a chair wearing a hospital gown, and stated they were wearing a hospital gown as this was all the clean clothing available to them. Their laundry was taken and not returned. Resident #32 stated they waited hours on the toilet for assistance, at times they did not receive shower or care overnight. Resident observed to be extremely hard of hearing. The resident did not have hearing aids applied, and hearing aids were seen in the resident's closet. Resident stated they asked for assistance in applying hearing aids, but staff would not assist.</p> <p>During an interview on 2/05/2024 at 11:50 AM, Licensed Practical Nurse #6 stated the resident refused their hearing aids. Licensed Practical Nurse #6 then walked to resident's room, located the hearing aids in resident's closet, and placed them on Resident #32. At the time of the observation, Resident #32 was very receptive and thankful to have hearing aids placed.</p> <p>Record review revealed Resident #32 did not have a comprehensive care plan to self-administer hearing aids.</p> <p>During an interview on 2/07/2024 at 10:48 AM, Registered Nurse #1 stated there were typically 4-5 certified Nurse Aides on day shift, 3-4 on evening shift, and 1-2 overnights. There were missed showers at times and sometimes residents refused, which was documented in their electronic record system. They stated only a few residents would get up on overnight shift; most residents preferred to get up between 7:00 AM and 8:00 AM which was not always doable. They stated since it was a rehabilitation unit, physical therapy would send a list of who needed to get up first. Registered Nurse #1 stated those needing physical therapy would be prioritized to get up first. Registered Nurse #1 stated they had no knowledge of Resident #32 not having clean clothing, that there were always clean clothes, and if not, residents could wear sweat pants and T-shirt provided by the facility.</p> <p>During an interview on 2/07/2024, Registered Nurse #6 acknowledged difficulty with new laundry service and stated that many residents complained once laundry was put in mesh bag to go out for cleaning, they never saw see their items again. Registered Nurse #6 stated there was a new service in place since 11/28/2023, that the Administrator was aware and as of two weeks ago, had hired a full-time, in-house laundry person to sort clothing for residents upon return for outside laundry service.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/07/2024 at 2:15 PM, Administrator #1 stated they were gradually reducing agency staff; had a recent Town Hall meeting and addressed staff answering call lights timely. Administrator #1 further stated that management had been working on individual units to address concerns, specifically answering call lights. Administrator #1 stated residents could file a grievance for any missed items, and that the facility was aware of Resident #32 grievances and in process of addressing their concerns. Administrator #1 stated grievances were addressed immediately, however, resolution could take 1-2 weeks depending on the depth of investigation.</p> <p>Resident #327</p> <p>The resident was admitted to the facility with the diagnoses of metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities), severe sepsis with septic shock (a serious condition in which the body responds improperly to an infection including possible organ failure), and cirrhosis of the liver (a condition where scar tissue gradually replaces liver tissue). The Minimum Data Set, dated dated [DATE] documented the resident could understand and be understood by others and was cognitively intact.</p> <p>The Kardex Report (list of Certified Nurse aide tasks) dated 2/28/2023 documented the resident was to receive a shower or bath every Tuesday and Thursday on the day shift. The Kardex Report documented the resident required the physical assistance of one staff member with bathing activity.</p> <p>The document titled Bathing for the dates 2/13/2023-2/28/2023, documented that no bath or shower were given to resident. On 2/21/2023 and 2/28/2023 the bathing activity was documented as NA or not applicable.</p> <p>During an interview on 2/12/2024 at 11:20 AM, Certified Nurse Aide #3 stated the resident should receive showers according to their Kardex. They stated they checked the Kardex for changes at the start of each shift. They stated if a resident refused a shower, they would inform the nurse and re-approach.</p> <p>During an interview on 2/12/2024 at 11:23 AM, Licensed Practical Nurse #5 stated that at the end of the shift, the nurse should check to make sure Certified Nurse Aide tasks were completed; this would include showers and bathing. Licensed Practical Nurse #5 stated they would expect the Certified Nurse Aide to inform the nurse if a resident refused a shower.</p> <p>During an interview on 2/12/2024 at 11:40 AM, Director of Nursing #1 stated audits should be performed at the end of the shift to ensure the Certified Nurse Aide accountability was completed and resident care had been completed. They stated they expected the Certified Nurse Aide and floor nurse (Licensed Practical Nurse or Registered Nurse) to communicate about any issues with resident care including if a resident refused care.</p> <p>10NYCRR 415.12(a)(3)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, record review, and interviews during a recertification and abbreviated survey (Case # NY00327311 and NY00315143) from 2/05/2024 to 2/12/2024, the facility did not ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents in the facility. Specifically, there was not sufficient staff to meet resident needs in activities of daily living; multiple residents stated there were long waits for call lights showers were not given, not gotten out of bed and dressed until late morning, long waits to return to bed, and not enough staff to provide care.</p> <p>This is evidenced by:</p> <p>The facility's staffing policy revised on 11/2023, documented staffing numbers and skills requirements of direct care staff were determined by the needs of the resident's care plan. The number of nursing staff on duty would be sufficient to ensure nursing care needs of each resident were met.</p> <p>The facility's Call Light System - Resident Response policy dated 12/2017, documented the purpose was to provide timely response to residents in need of assistance to ensure high quality resident outcomes; be sure call light was within easy reach of the resident; answer call light as soon as possible and check on resident frequently who may not be able to use call their call light.</p> <p>Resident #2</p> <p>The resident was admitted to the facility with the diagnoses of urinary tract infection, diabetes mellitus type 2, hypertension, hypothyroidism (underactive thyroid), and obesity. The Minimum Data Set (an assessment tool) dated 11/28/2023 documented the resident could understand and be understood by others and was cognitively intact.</p> <p>The comprehensive care plan initiated 9/22/2023 documented the resident required assistance with Activities of Daily Living related to limited mobility, Diabetes Mellitus, obesity, and inability to complete Activity of Daily Living tasks; Interventions included a total mechanical lift with assistance of 2 or more staff for transfers.</p> <p>The following observations of Resident #2 were made:</p> <p>On 2/05/2024 at 10:40 AM, resident was in bed wearing hospital gown.</p> <p>On 2/06/2024 at 11:00 AM, resident was in bed wearing hospital gown. Both resident and roommate stated they were waiting for Certified Nurse Aide to assist with morning care. Resident was noted to have left over breakfast on overbed table, face with crumbs and hair was disheveled.</p> <p>On 2/6/2024 at 11:10 AM, resident turned on call light, staff responded in 13 minutes and told resident they would be back.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/07/2024 at 10:13 AM, resident was in bed wearing hospital gown and stated they are waiting for assistance to get washed up.</p> <p>During an interview on 2/6/2024 at 11:15 AM, the resident stated staff only provided care to them once a day if that. Resident stated they waited a very long time for care. Resident stated they had a foley catheter secondary to urinary incontinence and required assistance after soiling briefs.</p> <p>Resident # 32</p> <p>The resident was admitted to the facility with the diagnoses of osteoarthritis, difficulty walking, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), weakness, and depression. The Minimum Data Set, dated dated dated [DATE] documented the resident could understand and be understood by others and was cognitively intact.</p> <p>The comprehensive care plan initiated 3/17/2017 and revised 11/2/2024 documented the resident required assistance with Activity of Daily Living tasks related to limited mobility, osteoarthritis, chronic left shoulder pain, and inability to complete Activity of Daily Living tasks. Resident was a partial assist with 1 staff helper, and the resident was to be encouraged to use a call light for assistance. Resident did not have a comprehensive care plan to self-administer hearing aids.</p> <p>Record review of grievances revealed the resident filed a grievance with the facility on 7/21/2023 for help during the night, and that they wait an hour and half for assistance.</p> <p>During an observation on 2/05/2024 at 12:59 PM, the resident's call light remained on for 20 minutes. It was noted that there were 6 staff in the vicinity of the resident's room that did not answer light, and that the staff instead went about other duties.</p> <p>During an interview on 2/05/2024 at 11:45 AM, the resident was observed in their room sitting in a chair. Resident observed to be extremely hard of hearing. The resident did not have hearing aids applied, and hearing aides were seen in the resident's closet. Resident stated they asked for assistance in applying hearing aids, but staff would not assist. Resident was wearing a hospital gown, and stated they were wearing a hospital gown as it was all the clean clothing available to them. Their laundry was taken and not returned. Resident stated they would wait for hours on the toilet for assistance, and at times they would not receive a shower or overnight care.</p> <p>During an interview on 2/05/2024 at 11:50 AM, Licensed Practical Nurse #6 stated the resident refused their hearing aids. Licensed Practical Nurse #6 then walked to resident's room, located the hearing aids in resident's closet, and placed them on Resident #32. At the time of the observation, Resident #32 was very receptive and thankful to have hearing aids placed.</p> <p>During an interview on 2/07/2024 at 10:48 AM, Registered Nurse #1 stated there were typically 4-5 Certified Nurse Aides on day shift, 3-4 on evening shift and, 1-2 overnights. Registered Nurse #1 further stated that there were missed showers at times, and sometimes residents refused. They stated that it would be documented in their electronic charting system; that only a few residents consented to getting up on the 11 PM - 7 AM shift. They stated that most residents preferred to get up between 7:00 AM - 8:00 AM which was not always doable. Registered Nurse #1 further stated that on the rehabilitation unit, physical therapy would send a list of who needed to get up first, and residents needing physical therapy would be prioritized to get up first.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Troy Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 49 Marvin Avenue Troy, NY 12180	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/07/2024 at 02:15 PM, Administrator #1 stated they were gradually reducing agency staff; had a recent Town Hall meeting and addressed staff answering call lights timely. They further stated that management had been working on individual units to address concerns, specifically answering call lights. Administrator #1 stated that, at times, staff on orientation were counted as regular staff, depending on their progress during orientation.</p> <p>Resident #327</p> <p>The resident was admitted to the facility with the diagnoses of metabolic encephalopathy (a series of neurological disorders not caused by primary structural abnormalities), severe sepsis with septic shock (a condition in which the body responds improperly to an infection including possible organ failure), and cirrhosis of the liver (a condition where scar tissue gradually replaces liver tissue). The Minimum Data Set, dated dated [DATE] documented the resident could understand and be understood by others and was cognitively intact.</p> <p>The Kardex Report (list of certified nurse aide tasks) dated 2/28/2023 documented the resident was to receive a shower or bath every Tuesday and Thursday on the day shift. The Kardex Report documented the resident required the physical assistance of one staff member with bathing activity.</p> <p>The document titled Bathing for the dates 2/13/2023-2/28/2023 documented that no bath or shower was given to resident. On 2/21/2023 and 2/28/2023, the bathing activity was documented as NA or not applicable.</p> <p>During an interview on 2/12/2024 at 11:20 AM, Certified Nurse Aide #3 stated residents should receive showers according to their Kardex. They stated they check the Kardex for changes at the start of each shift. They stated if a resident refused a shower, they would inform the nurse and re-approach.</p> <p>During an interview on 2/12/2024 at 11:23 AM, Licensed Practical Nurse #5 stated that at the end of the shift, the nurse should check to make sure Certified Nurse Aide tasks were completed; this would include showers and bathing. Licensed Practical Nurse #5 stated they would expect the Certified Nurse Aide to inform the nurse if a resident refused a shower.</p> <p>During an interview on 2/12/2024 at 11:40 AM, Director of Nursing #1 stated audits should be performed at the end of the shift to ensure the Certified Nurse Aide accountability was complete and resident care had been completed. They stated they expected the Certified Nurse Aide and floor nurse (Licensed Practical Nurse or Registered Nurse) to communicate about any issues with resident care including if a resident refused care.</p> <p>During an interview in Resident Council meeting on 2/05/2024 at 1:40 PM,</p> <ul style="list-style-type: none"> - Resident #s 61, 44 and 36 stated average wait time for call light was between 15 to 20 minutes during the day, with overnights taking more time and staff did not help each other out, it is like nobody there. If a certified nurse aide is assigned to you, the other certified nurse aides would not touch you. - Resident # 61 stated they had sat on toilet until legs went numb. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident # 36 stated they had sat in wet pads for hours.</p> <p>During an interview on 2/06/2024 at 11:38 AM, Resident #67 stated at about 4:00 AM on 2/05/2024, they activated their call light and called out for help because of extreme pain and needed a pain pill. They stated that as they were crying out in pain, they heard staff outside in hallway talking and laughing, and no one came to answer the active call bell light until the day shift arrived. In an observation at this time, Resident #67's status was noted to include post amputation of left lower extremity.</p> <p>During an interview on 2/09/2024 at 10:56 AM, Resident # 11 stated their call light was on for 35 minutes, Certified Nurse Aide #4 came in and shut light off. Resident #11 stated Certified Nurse Aide #4 told the resident that there were only three aides on the floor and were assisting other residents, so Resident #11 would have to wait.</p> <p>During an interview on 2/09/2024 at 12:43 PM, Certified Nurse Aide # 2 stated there were only 3 certified nurse aides on the floor at the time Resident #11 turned their light on to facilitate their return to bed. Certified Nurse Aide #1 further stated that 1 Certified Nurse Aide was giving a shower, and the other was providing patient care. Certified Nurse Aide #1 stated the resident was told they would have to wait as no certified nurse aide was available immediately to put them back in bed.</p> <p>During an interview on 2/09/2024 at 1:54 PM, Administrator #1 stated all staff assist each other on the floor, including supervisors and managers. They further stated that the supervisor went to the floor to assist staff and Resident #11, and an investigation was initiated.</p> <p>The facility's daily staffing schedule dated 2/02/2024 - 2/05/2024 documented the following:</p> <p>02/02/2024 North Unit, Day shift (7:00 AM - 3:00 PM) - 1 Licensed Practical Nurse and 4 Certified Nurse Aides for 39 residents. South Unit 2 Licensed Practical Nurses, 1 Registered Nurse on orientation, and 4 Certified Nurse Aide for 39 residents.</p> <p>02/02/2024 North Unit, Evening shift (3:00 PM - 11:00 PM) - 1 Licensed Practical Nurse and 4 Certified Nurse Aides, 1 Certified Nurse Aide on orientation for 39 residents. South Unit 2 Licensed Practical Nurses, and 5 Certified Nurse Aide for 39 residents.</p> <p>02/02/2024 North Unit, Night shift (11:00 PM - 07:00 AM) - 1 Licensed Practical Nurse on orientation and 3 Certified Nurse Aides, for 39 residents. South Unit 1 Licensed Practical Nurse, and 2 Certified Nurse Aide for 39 residents.</p> <p>02/03/2024 North Unit, Day shift (7:00 AM - 3:00 PM) - 2 Licensed Practical Nurses, 4 Certified Nurse Aides and 1 Certified Nurse Aide on orientation, for 39 residents. South Unit 3 Licensed Practical Nurses, and 3 Certified Nurse Aides for 39 residents.</p> <p>02/03/2024 North Unit, Evening shift (3:00 PM - 11:00 PM) - 2 Licensed Practical Nurses and 4 Certified Nurse Aides, for 39 residents. South Unit 2 Licensed Practical Nurses, 1 Licensed Practical Nurse on orientation and 4 Certified Nurse Aide for 39 residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>02/03/2024 North Unit, Night shift (11:00 PM - 07:00 AM) - 1 Licensed Practical Nurse on orientation and 2 Certified Nurse Aides, for 39 residents. South Unit 1 Licensed Practical Nurse, 2 Certified Nurse Aide and 1 Certified Nurse Aide on orientation for 39 residents.</p> <p>02/04/2024 North Unit, Day shift (7:00 AM - 3:00 PM) - 2 Licensed Practical Nurses, 4 Certified Nurse Aides and 1 Certified Nurse Aide on orientation, for 39 residents. South Unit 2 Licensed Practical Nurses, and 3 Certified Nurse Aides for 39 residents.</p> <p>02/04/2024 North Unit, Evening shift (3:00 PM - 11:00 PM) - 2 Licensed Practical Nurses and 3 Certified Nurse Aides, for 39 residents. South Unit 2 Licensed Practical Nurses, 1 Licensed Practical Nurse on orientation and 4 Certified Nurse Aide for 39 residents.</p> <p>02/04/2024 North Unit, Night shift (11:00 PM - 07:00 AM) - 1 Licensed Practical Nurse on orientation and 2 Certified Nurse Aides, for 39 residents. South Unit 1 Licensed Practical Nurse, 2 Certified Nurse Aide and 1 Certified Nurse Aide on orientation for 39 residents.</p> <p>02/05/2024 North Unit, Day shift (7:00 AM - 3:00 PM) - 2 Licensed Practical Nurses, 4 Certified Nurse Aides and 2 Certified Nurse Aides on orientation, for 39 residents. South Unit 1 Licensed Practical Nurses, 1 Registered Nurse on orientation, and 5 Certified Nurse Aides for 39 residents.</p> <p>02/05/2024 North Unit, Evening shift (3:00 PM - 11:00 PM) - 2 Licensed Practical Nurses and 3 Certified Nurse Aides, for 39 residents. South Unit 1 Licensed Practical Nurse, 1 Licensed Practical Nurse on orientation and 4 Certified Nurse Aide for 39 residents.</p> <p>02/05/2024 North Unit, Night shift (11:00 PM - 07:00 AM) - 1 Licensed Practical Nurse on orientation and 2 Certified Nurse Aides, for 39 residents. South Unit 1 Licensed Practical Nurse, 1 Certified Nurse Aide for 39 residents.</p> <p>10NYCRR 415. (a)(1) (i-iii)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414</p> <p>Based on observation, record review, and interviews during the recertification survey from 2/05/2024 to 2/12/2024, the facility did not adequately provide for residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area on one (1) of 2 units. Specifically, the facility nurse call system did not function in resident room #s 5, 7, and 11 on the North Unit.</p> <p>This is evidenced by:</p> <p>During observations on 2/08/2024 at 9:33 AM, the call bell did not activate when tested in resident room # 5 for beds A and B. Additionally, room [ROOM NUMBER] was utilizing tap bells and did not have nurse cords to activate the nurse call system. room [ROOM NUMBER] was utilizing a tap bell and did not have a nurse call cord to activate the nurse call system.</p> <p>During an interview on 2/08/2024 at 9:37 AM, Resident #8 stated that they would press the nurse call cord if one were provided.</p> <p>Record review of [NAME] Center Repair Requisitions, dated 12/26/2023, documented that the nurse call system in room [ROOM NUMBER] and room [ROOM NUMBER] were in disrepair.</p> <p>Record review of [NAME] Center Repair Requisition, dated 12/30/2023, documented that the nurse call system in room [ROOM NUMBER] was in disrepair.</p> <p>The document titled [vendor] Quote documented that the facility obtained a quote to affect repairs to the call bell system on 1/09/2024.</p> <p>During an interview on 2/08/2024 at 9:44 AM, Maintenance Life Safety Consultant #1 stated that the facility had contracted with a vendor to repair the nurse call systems in 3 resident rooms and was presently awaiting to schedule a starting date once the vendor had all the replacement parts.</p> <p>During an interview on 2/12/2024 at 10:33 AM, Administrator #1 stated that the repairs to the call bell system were completed.</p> <p>10 New York Codes, Rules and Regulations 713-1.3(b)</p>		