STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335291	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Point Rehabilitation and Nursing Center	3700 Old Vestal Road Vestal, NY 13850

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34996 Based on observation, record review, and interview during the recertification and abbreviated (NY00328316) surveys conducted 3/18/2024-3/29/2024 the facility did not ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 3 residents (Resident #223) reviewed. Specifically, Resident #223 had an order for a vacuum assisted closure device (a device that uses negative pressure for wound healing) and the device was observed unplugged and not functioning. Findings include: The facility policy titled Wounds-Nursing care of a V.A.C. (vacuum assisted closure) Pump last modified 1/9/2019 documented the vacuum assisted closure device should always be in optimum working order while being used to heal a resident. During each shift, the pump should be checked to ensure it was on. If unable to maintain integrity of the system after 30 minutes, contact the Wound Care Nurse. Resident #223 was admitted to the facility with diagnoses including surgical aftercare following surgery on the skin and subcutaneous tissue and unspecified open wound of the abdominal wall. The 1/3/2024 Minimum Data Set assessment documented the resident was cognitively intact, dependent for personal hygiene, had a surgical wound, and received surgical wound care. A 12/27/2023 hospital discharge summary documented the resident had a panniculectomy (removal of abdominal excess skin and fat tissue). A wound vacuum assisted closure device was placed. The resident subsequently was found to have necrotic (dead) foul smelling tissue and the wound was debrided (removal of dead tissue) and washed out. The wound culture was positive for the presence of several bacteria. The wound was healing well, and the resident was cleared for discharge. Discharge instructions documented dressing change as needed for vacuum assisted closure device. A 12/27/2023 at 2:16 PM registered nurse #30 initial nursing note documented the resident had an abdominal wound following necrosis at the site of the panniculectomy with a wound vac (vacuum assisted closure device). (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/27/2023 facility admission order documented cleanse 3 abdominal wounds with normal saline, skin prep to surrounding skin, pack tunneling with white foam, cover wound beds with black foam, then transparent cover, bridge together with suction off of wound bed, then cover with a track pad, place negative pressure wound therapy with settings at 125 millimeters of mercury continuously every Monday, Wednesday and Friday and as needed. Monitor placement, suction/settings 125 millimeters of mercury, cannister every shift. The comprehensive care plan, initiated 12/27/2023, documented the resident had impaired skin integrity due to necrosis at the site of the panniculectomy with a wound vacuum assisted closure device. Interventions included monitor every shift for signs and symptoms of infection, monitor wound vacuum assisted closure device functioning, and dressing changes per physician order. A 2/12/2024 updated physician order documented cleanse mid abdominal wound with normal saline, apply skin prep (a skin protectant) to surrounding skin, pack tunnelling with white foam, cover wound beds with black foam, then transparent, bridge together with suction off the wound bed, then cover with a track pad, place negative pressure wound therapy (vacuum assisted closure device) with setting at 125 milligrams continuously. Change every Monday, Wednesday, and Friday and as needed. A 2/27/2024 physician #4 progress note documented the resident had a wound in the lower abdominal area. The resident had been treated with intravenous antibiotics for an extended duration due to wound infection. The resident was not currently on antibiotics. The wound vacuum assisted closure device was in place. Staff were spoken to in detail about the wound care treatment plan. A 3/27/2024 at 3:45 PM registered nurse #30 nursing progress note documented the resident was sent to the emergency department after a fall. A 3/27/2024 at 11:30 PM registered nurse #34 progress note documented the resident returned from the emergency department. There was no documented evidence the resident was assessed, or the wound vacuum assisted closure device was in place and functioning upon return from the hospital. The 3/1/20424-3/31/2024 medication and treatment administration records did not include wound vacuum assisted closure device orders for a dressing or for monitoring of the device. During an observation and interview on 3/28/24 at 8:46 AM, the resident was lying in bed in a gown, covered with blankets. The resident stated they fell yesterday, went to the hospital, and got back around 11:00 PM. The resident pulled back their blankets to expose the wound vacuum assisted closure device tubing and apologized for the odor as the canister gets full. The device was in the top drawer of the bedside stand. The device screen was dark and silent, the canister contained a trace amount (less than 30 milliliters) of dark red/yellow drainage, and the power cord was not plugged into an electrical outlet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/28/2024 at 10:19 AM, the resident was lying on their back in bed. They returned from the hospital last night and was assisted into bed and the wound vacuum assisted closure device was placed in the top drawer of their bedside stand. They stated the nurses did not check it, just when they changed the dressing. They stated they needed the dressing done today because they were at the hospital yesterday and it was not done. The top drawer of the bedside stand contained the wound vacuum assisted closure device. The device was off, and the screen was dark with no sound emitting from machine. The device was not plugged into an electrical outlet. There was a scant amount dark red and yellow drainage in the canister. The occupational therapist entered the room with an ice pack and therapy equipment at 10:40 AM. During an observation and interview on 3/28/24 at 11:48 AM the resident was lying in bed with the wound vacuum assisted closure device on. There was thin red serosanguinous (red tinged fluid) liquid visible in the tubing. The screen display read 125 milligrams of mercury. Certified nurse aide #35 stated at the time of the observation the wound vacuum assisted closure device care was not done by the certified nurse aides. They stated they would unplug the cord and place the unit on the back of the chair when they transported the resident and plugged it in if it beeped for a low battery, but otherwise they did not touch it. During an interview on 3/28/24 at 11:55 AM, licensed practical nurse #36 stated they administered the resident's medications at around 8:00 AM that morning and they could see fluid movement in the tubing of the wound vacuum assisted closure device. They did not see anything wrong with the tubing or the machine, so they signed off on it in the treatment administration record. If there was something wrong with the machine, they would notify a registered nurse as licensed practical nurses did not do the treatment or handle the intricate controls of the device. During an interview on 3/28/24 12:07 PM occupational therapist #37 stated the resident asked them if the wound vacuum assisted closure device was working when they entered their room earlier and they went and got registered nurse #30 who came right in and assessed the unit and the resident. During an interview on 3/28/2024 at 12:09 PM registered nurse #30 stated occupational therapist #37 alerted them the resident had concerns with their wound vacuum assisted closure device. They assessed the wound vacuum assisted closure device and it was off, so they turned it on. They did not know how long it had been off. When they turned it on and it was working as ordered, so they had no concerns. During an interview on 3/28/2024 at 1:39 PM licensed practical nurse #38 stated if the wound vacuum assisted closure device was off it should be immediately assessed, and the dressing should be changed. The physician should be notified it was off especially because they did not know how long it was off. The provider should be contacted for guidance prior to just turning the device back on as it was ordered to run continuously. Healing could be delayed, and bacteria build up could cause an infection. If the wound vacuum assisted closure device was off there should have been a wet to dry dressing applied until the ordered treatment could be completed by qualified staff. During an interview on 3/28/2024 at 1:47 PM registered nurse #39 stated they were not aware the wound vacuum assisted closure device was off or how long it was off. The device should not just be turned back on without knowing how long it was off. The machine lost suction when it was off, and bacteria could develop in the dressing from the fluid back up. The nurse and medical should be notified it was off. The purpose of the device was to draw drainage away from the wound to promote healing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a treatment observation on 3/28/24 at 1:59 PM, registered nurse #30 removed the resident's wound vacuum assisted closure device foam dressing. There was moderate serosanguinous wound drainage. The wound was pink and moist. The edges of the wound were in various stages of healing and were clean, dry, and light pink. During an interview on 3/28/2024 at 4:05 PM nurse practitioner #40 stated licensed practical nurse #30 called them around 2:00 PM this day and stated that the resident's wound vacuum assisted closure device was off and they were unsure how long it had been off. They stated the wound vacuum assisted closure device drained the fluid away from the wound to allow for wound healing. The wound vacuum assisted closure device should not be turned off until it was time for a dressing change. If the device remained off, they were concerned for a delay in the wound healing process. They stated the device should not have been turned back on once it was found to be off. 10NYCRR 415.12 48632

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33421 Based on observation, record review and interview during the recertification and abbreviated (NY00314754, NY00319010, NY00320020, NY00327419, NY00331182, and NY00334923) surveys conducted 3/18/2024-3/29/2024 the facility failed to provide adequate supervision to prevent accidents for 4 of 10 residents (Residents #114, #174, #191, and #213) reviewed. Specifically, Residents #114, #191, and #213 were subjected to physical aggression and sexually abusive behaviors by Resident #174 and the facility failed to develop or implement strategic interventions for Resident #174 to protect other residents from victimization. Subsequently, Resident #174 pushed Resident #114 causing Resident #114 to sustain a hip fracture; Residents #174 and #213 were found in sexually inappropriate situations three times; and Resident #174 pushed Resident #191 causing them to hit their head against a wall causing an abrasion. This resulted in harm to Residents #191 and #114 that was not immediate jeopardy. Findings include: The facility policy Abuse Prevention modified 3/2019 documents the facility would not permit residents to be subjected to abuse by other residents. Residents will be provided with appropriate clinical care and treatment and will be cared for according to the individualized care plan. Incidents of resident-to-resident altercations must be reported to the Administrator and addressed by the interdisciplinary team members and care planned accordingly. In such instances the resident that is the perpetrator and all residents who may be vulnerable to the perpetrating resident must have their care documented with immediate safety action taken. The facility policy Behavior Protocol-Handling Problem Behaviors modified 2/2019 documents that all disciplines will implement appropriate strategies to eliminate problem behaviors which may cause emotional and physical problems to both residents and staff. Staff will document in the electronic medical record interventions which were used to attempt to eliminate the behavior, indicating if the interventions were successful. The attending physician/nurse practitioner will be consulted for further recommendations and/or interventions/orders. Resident #174 had diagnoses including frontotemporal neurocognitive disorder (dementia caused by damage to neurons in the frontal and temporal lobes of the brain), aphasia (difficulty expressing themself), and wandering. The 3/15/2023 Minimum Data Set documented the resident had severe cognitive impairment and did not exhibit physical or verbal behavioral symptoms directed toward others. The 9/5/2023 Minimum Data Set assessment documented the resident had intact cognition, verbal behaviors directed toward others for 1-3 of 7 days, other behavioral symptoms not directed toward others for 1-3 of 7 days, wandered for 1-3 of 7 days, was independent with most activities of daily living, received a daily antidepressant, and used a wander alarm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Resident #174's comprehensive care plan initiated 10/10/2022 and updated 2/27/2023 documented the resident had confusion, wandered, had potential to be verbally aggressive, liked to kiss peers on the forehead and rub back/shoulders, had dementia, had potential for physical aggressiveness, and had behavior problems. Interventions included remind of socially acceptable behaviors, invite to small groups, music in room, 1:1 supervision if needed, independent activity materials provided, walk, TV, care magazines, movies, assess for fall risk, wander risk tool at admission/quarterly/as needed, distract, redirect, wander detection device on right ankle, intervene immediately, encourage to visit peers in public areas, avoid taking inappropriate behaviors lightly, separate residents if sexually inappropriate behaviors noted, medications as ordered, remove from situation, and close door if masturbating. Resident #114 had diagnoses including impulsiveness, emotional lability (rapid, often exaggerated changes in mood), and aphasia (difficulty speaking). The 3/21/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not wander, and required supervision when walking in the corridor and locomotion on the unit. Resident #191 had diagnoses including dementia, anxiety, and insomnia. The 6/1/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, had physical and verbal behavioral symptoms directed toward others for 1-3 of 7 days, wandered for 4-6 of 7 days, required supervision of 1 for walking in the corridor and locomotion on the unit, did not use mobility devices, and used a wander alarm daily. Resident #213 had diagnoses including Alzheimer's disease, restlessness and agitation, and wandering. The 11/15/2023 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit behavioral symptoms, did not wander, required partial/moderate assistance with walking, and did not use a wander alert device. Nursing progress notes for Resident # 174 documented: - from 1/9/2023 -2/19/2023, the resident exhibited aggressive behaviors including throwing items, slamming, and kicking their door, standing in the hall naked, wandering the unit, becoming impatient and agitated with other residents, swinging at staff, touching other residents, and allowing other residents to touch them, - on 1/20/2023 the resident was examined by the physician with a new order for Celexa (antidepressant). - on 2/24/2023 at 5:04 PM, staff witnessed Resident #174, and another resident enter Resident #174's room and close the door. Staff entered and witnessed the other resident rubbing Resident #174's genitals, both residents were fully clothed. The residents were separated, and Resident #174 was placed on 1:1 supervision, monitored for 72 hours, and the physician was notified. - on 2/27/2023 at 2:10 PM, the physician was updated on the resident's behaviors and a new order was to discontinue Celexa and start Prozac 20 milligrams daily for inappropriate sexual behaviors. - from 2/24/2023-3/1/2023, documented 1:1 supervision continued - on 3/1/2023 at 11:00 AM, 1:1 supervision was completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Resident #174's comprehensive care plan was revised on 2/27/2023. Another resident was witnessed rubbing Resident #174's genitals over their pants, both residents were fully clothed. Interventions included avoid taking inappropriate behaviors lightly or dismissing as a fluke. Provide 1:1 supervision if indicated. A 3/2/2023 psychiatric nurse practitioner #21 progress note documented the resident was seen per request of staff for frontotemporal dementia with behaviors and sexually inappropriate behaviors. Staff reported sexually inappropriate behaviors of masturbating, and giving attention to other residents, including rubbing their backs. The resident had not touched anyone on private areas of the body. Otherwise, staff did not report any aggression. There was an episode where staff found the resident with a female in their room who was rubbing the resident's genitals over their pants, but both residents were fully clothed, and they were separated. Selective serotonin reuptake inhibitors (antidepressants) can help manage behaviors associated with dementia. If sexually inappropriate behaviors continue, they would recommend starting Tagamet twice a day. The resident would be followed in 2-4 weeks. Nursing progress notes documented: -on 3/4/2023 at 9:43 PM, staff were watching the resident with females as the resident had been petting their hands all day. Staff made sure the resident was not taking anything further. - on 3/12/2023 at 1:08 PM, the resident was following another resident around attempting to play with their hair, at one point staff intervened with gentle direction. - on 3/15/2023 at 1:16 PM, the physician increased Prozac to 30 milligrams daily. - on 3/17/2023 at 2:19 PM, walking around trying to get another resident to go in their room. They proceeded to follow the resident around and was redirected back to their room. - from 3/18/2023-4/13/2023 episodes of slamming and hitting the door, throwing things in their room, and becoming agitated with other residents. A 4/5/2023 physician #18 progress note documented the resident had frontotemporal dementia with negative behaviors and poor impulse control. The increased dose of Prozac would be continued. The resident was definitely doing better according to aides with regards to negative behaviors and mood lability. A 4/14/2023 Accident/Incident Report for Resident #174 completed by registered nurse Unit Manager #24 documented at 7:00 AM, staff heard a thud and found Resident #114 on the floor against the closet of Resident #174's room. Resident #174 was standing near Resident #114 and stated they pushed Resident #114 because they were in their room. Immediate interventions included registered nurse assessment and aggressive behavior monitoring for 72 hours. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A 4/14/2023 Accident/Incident Report for Resident #114 completed by Registered Nurse Unit Manager #24 documented at 7:00 AM, Resident #114 was found in Resident #174's room on the floor. Resident #114 stated Resident #174 pushed them. Neuro checks were at baseline, no injury to head, moving all extremities, and without pain. Transferred with assistance of 2 and resident complained of left hip/leg pain once weight bearing. The resident was transported to bed in a wheelchair and was awaiting transport to hospital for evaluation. A 4/14/2023 at 12:44 PM, Registered Nurse Unit Manager #24's progress note documented they called the hospital to check on the status of Resident #114 and was told the resident had a left hip fracture and was waiting for orthopedics. Resident #114's comprehensive care plan initiated 8/23/2022 documented the resident had potential to be physically aggressive related to anger at placement may strike at others. Interventions included to intervene when agitated before escalation and guide away from source of distress. A 4/14/2023 at 2:36 PM, social worker #26 progress note documented they spoke to Resident #174 following the incident with their peer. The resident reported they pushed Resident #114 out of their room. Resident #174 was reminded to ask staff for help if they were bothered or concerned. Resident #174's 4/14/2023 updated comprehensive care plan documented the resident had potential for physical aggressiveness and pushed a peer who wandered into their room causing a fall. Interventions included move peers out of harm's way, remind resident they could cause harm, privacy curtain on doorway, stop sign across door to prevent peers from entering room, may close door for privacy and to keep peers from entering room. Resident #114's comprehensive care plan initiated 4/14/2023 documented the resident had potential to be a victim of abuse related to another resident's intrusive behavior. Resident was found on the floor of Resident #174's room. Interventions included provide environmental barriers to ensure safety-stop sign placed in doorway of Resident #174 to deter Resident #114 from entering. A 4/15/2023 physician #18 progress note documented Resident #174 had aggressive behaviors and poor impulse control, at times. The resident was more mellow with increased dose of Prozac. The plan was to continue the present dose of Prozac 30 milligrams daily and the resident was doing better with negative behaviors and mood lability. A 5/10/2023 physician #18 progress note documented the resident had occasional issues with poor impulse control, verbally and physically. The resident was not perceived as a danger to staff or others. The increase in Prozac seemed to have helped. Nursing notes for Resident #174 documented: - on 5/10/223 at 3:16 PM, the resident was redirected by staff for trying to remove other residents from their room. The resident was reminded to seek staff assistance. The stop sign in doorway was replaced as the resident kept removing and placing it in their closet. - on 5/18/2023 at 10:22 PM the resident was observed trying to kiss another resident on the mouth. Typically, the resident would kiss on the cheek. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	- on 5/28/2023 at 9:50 PM, the resident became agitated with another resident when they took the stuffed animals they were playing with. Resident #174 followed the resident and raised their arms toward them, but staff quickly intervened and separated the residents. - on 5/30/2023 at 3:14 PM the resident threw a stuffed animal at another resident A 7/4/2023 Accident/Incident Report completed by illegible name and title documented at 7:15 PM, Resident #191 was in Resident #174's room. Resident #174 was telling Resident #191 to leave the room. Resident #191 left the room and Resident #174 pushed Resident #191 on the upper back, causing Resident #191 to shuffle forward. Resident #191 did not fall. Resident #191 was assessed without injury and redirected away from Resident #174. Resident #191 was redirected to their room without further issues. Both residents would be monitored for a minimum of 72 hours for signs of fearfulness or change in behavior. Resident #191 would be monitored for a minimum of 72 hours for aggressive behavior. The plan of care was followed. Resident #191's care plan was updated on 7/4/2023 to include the resident was subject to physical aggression from peers. Interventions included resident would be free of physical aggression by peers. The care plan did not identify new interventions to ensure the resident was free from aggression by peers. Resident #174's care plan was revised on 7/4/2023 to include the resident had potential to be physically aggressive (initiated 2/27/2023) and pushed a peer up against the wall. There were no additional documented interventions. The 7/7/2023 physician #18 progress note documented Resident #174 had their own room and occasionally had negative behaviors with other residents wandering into their room. Staff did their best to avoid the situation. Resident #174 was usually peaceful but became agitated when others wandered into their space. A gradual dose reduction of medication was not currently indicated. Nursing notes for Resident #174 documented: - on 7/27/2023 at 9:17 PM the resident attempted to hit another resident and was redirected. - on 8/4/2023 at 10:46 PM the resident kept throwing a book across the room and ripping out pages. When asked by staff to go to their room they started slamming and kicking the door and kicked a staff in the legs. - on 8/7/2023 psychiatric nurse practitioner #21 was updated on the resident's aggressive behavior and ordered gabapentin 100 milligrams three times daily for agitation. - No negative behaviors were documented from 8/8/2023-8/31/2023. - on 9/1/2023 at 10:32 PM the resident was yelling at another resident, was asked to go to their room, and began kicking the door of their room. - on 9/11/2023 at 7:40 PM the resident had a verbal altercation with another resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	- on 10/5/2023 at 6:31 AM, note states, at 1:30 AM the resident was sitting next to a female resident who was sleeping. The resident attempted to place their hands inside of the female resident's inner thigh. A 10/9/2023 Accident/Incident Report completed by Registered Nurse Unit Manager #24 documented at 3:15 PM Resident #191 was witnessed in Resident #174's room falling to the floor, hitting the right side of their head on the wall as they fell . Resident #174 was standing over Resident #191 then walking away. Resident #191 was crying and would not give a statement. The nurse practitioner examined Resident #191. The resident had a small abrasion on the right ear that required treatment. The resident was wandering per usual shortly thereafter. The care plan was followed, and the plan was to monitor for 72 hours. An unsigned narrative included with the report documented Resident #174 stated they pushed Resident #191 because they were in their room. Both residents would be monitored for a minimum of 72 hours for signs of fearfulness, change in behavior, and aggression. Resident #174 was placed on aggressive behavior charting for a minimum of 72 hours. Resident #191's care plan was revised to include pushed by peer on 10/9/2023. There were no documented revised interventions to ensure the resident remained free of accident hazards. Resident #174's care plan was revised to include they pushed their peer on 10/9/2023. There were no documented revised interventions to protect other residents from aggressive behaviors. On 11/3/2023 at 9:54 PM the resident was reported to be standing over a peer while sleeping and was redirected. The 11/8/2023 nurse practitioner #20 progress note documented Resident #174 could be easily irritable and agitated with staff and other residents. The resident was currently on gabapentin and Prozac. Typically, the resident was easily redirected. The plan was to continue gabapentin and Prozac and non-pharmaceutical interventions. No gradual dose reduction of medication was indicated. A 12/10/2023 Accident/Incident Report completed by illegible name and title documented at 3:45 PM the Supervisor and unit nurse notified them Resident #213 was observed in the dining room sitting on Resident #174's lap. Resident #174 was fondling Resident #213's breasts. The residents were separated. There were no signs of physical or emotional trauma. The included unsigned narrative documented Resident #174 had demonstrated physical behaviors directed toward others as evidence by masturbating with their door open, mutual touching of genitals, had potential to be physically aggressive, went into other resident's rooms, and was exit seeking. Both residents would be monitored for a minimum of 72 hours for any change in behaviors, fearfulness, or aggression. Resident #213's care plan initiated 12/12/2023 documented the resident had the potential for being a victim of abuse related to another resident's behavior, inappropriate closeness, and intrusive behavior. Interventions included redirect resident away from male peers with known history of sexually inappropriate behavior, discourage from rubbing and kissing peers, encourage, and praise appropriate interactions with peers, and encourage attendance at activities to prevent boredom. Resident #174's care plan was revised on 12/10/2023 to include resident was noted rubbing Resident #213 on the outside of their shirt while sitting on their lap. There were no revised interventions to protect other residents from inappropriate behaviors. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A nursing progress noted dated 12/11/2023 at 3:31 PM document Resident #174 was agitated. The resident was given space and left alone to calm down. The resident went to their room and returned for breakfast. The resident was seen touching a peer and staff intervened. The 1/3/2024 physician #19 progress note documented Resident #174 had increased outbursts and behaviors with staff and other residents. Staff had stated they have not noted any changes in resident behaviors that would be detrimental. The resident was easily redirected and able to maintain independence. The resident had good behavioral control with Prozac 10 milligrams daily and gabapentin 100 milligrams three times a day for agitation. The resident followed directions and was primarily aphasic (did not speak clearly). Aggressive behaviors had been controlled with current medication dosages. Nursing staff had no concerns with overall behaviors. An Accident/Incident Report dated 2/20/2024 completed by illegible registered nurse documented at 2:15 PM Resident #174 was found with a peer laying across them fully clothed on Resident #174's bed. Resident #174's hand was on the resident's groin. Staff immediately separated the residents. Immediate interventions included registered nurse assessment, separation of the residents, and behavior forms were initiated. A nursing note dated 2/22/2024 at 10:34 AM documented Resident #174 was rubbing a couple of residents' knees while sitting on the couch in the TV area. The residents were asleep on the couch. A nursing note dated 2/24/2024 at 9:51 PM documented Resident #174 was lying in their bed with another resident who was fully clothed. Resident #174 had their pants down with an erect penis. The residents were separated. Resident #174 was placed on 30-minute safety checks. An Accident/Incident Report dated 2/24/2023 at 8:15 PM completed by illegible licensed practical nurse documented they were called to the unit for witnessed sexually inappropriate behavior. Resident #213 was in Resident #174's room. Resident #174 had their pants down with an erect penis. The residents were separated immediately, and Resident #213 denied pain or discomfort. Immediate interventions included the residents were separated, 15-minute checks, registered nurse assessment and transfer to appropriate unit when available (did not indicate which resident would be transferred). There was no documented evidence Resident #174's comprehensive care plan was revised to include interventions to keep other resident's safe from aggression and sexual contact by Resident #174. A nursing progress note dated 2/25/2024 at 9:24 PM documented the resident exited the dining room with their pants halfway down and had an erection. At 9:35 PM the resident was found standing in another resident's room while the other resident was sleeping. The other resident's blanket was pulled down and their brief was exposed. Resident #174 was redirected and encouraged not to go in other's rooms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/20/2024 at 9:47 AM, certified nurse aide #22 stated for a resident-to-resident incident, staff tried to keep them away from each other post incident. They received dementia training about 3 months ago and were taught to redirect using various methods, try to deescalate the situation, remove the residents from the situation, and walk with the residents. Those techniques were also used to prevent residents from wandering into others' rooms. The facility had used stop signs in the past, but the facility stopped using them on the dementia unit. The aide did not know why the stop sign usage stopped. Resident specific interventions were listed on a resident's care instructions. The dementia unit had multiple residents that wandered. Resident #174 was sexually inappropriate at times and the facility implemented a door sensor in the room doorway about 3 weeks ago. The aide stated that Resident #114 was wandering the unit the morning of 4/14/2023. The aide was providing care to another resident on 4/14/2023 when they heard a thud in Resident #174's room, entered the room, saw Resident #114's feet as they were leaning against the wall by the closet, and Resident #114 was moaning. Resident #174 stepped out of the room after Resident #114 stated Resident #174 pushed them and left the room. There was no stop sign on the door prior to the incident. Resident #174 had not been aggressive with any residents prior to that incident. Resident #174 usually exited their room to get a staff member to deal with the situation. Staff tried to supervise the resident's room at least every 20-30 minutes. Staff used a 1:1 intervention frequently on the unit. Resident #174 could be sexual and had a door sensor on their room. Resident #213 also had sexual behaviors and they were moved for that reason. When the door sensor alarm went off, they checked to see if another resident went into Resident #174's room. The door sensor was implemented about a month ago. They tried to keep eye on the door and check but there were no set times and tried every 20-30 minutes. During an interview on 3/21/2024 at 12:11 PM, certified nurse aide #23 stated resident-specific interventions were documented in the care instructions. The main interventions used were reapproach, redirect, offer food/fluids, and intervene. Resident #191 was frequently in other residents' spaces and wandered the unit. Staff tried to keep a close eye on residents but that depended on staffing numbers. Resident #174 was a younger resident who still had a lot of sexual urges/needs. Prior to putting a door sensor on Resident #174's room door recently, staff frequently rounded the unit and tried to keep an eye on their room. Resident #174 only lashed out if certain residents went into their room. Resident #174's room door was usually kept closed and they previously had a stop sign across the doorway. The aide did not know what happened to it. Resident #213 was moved off the unit as they had liked to get intimate with male residents, particularly Resident #174. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an interview on 3/21/2024 at 1:10 PM, Registered Nurse Manager #24 stated there were independent activities kept on the dementia unit to use as distraction for some residents. Unit staff tried to keep known aggressive residents away from residents they tended to target. Staff had tried stop signs and curtains as deterrents from wanderers going into others' rooms. The residents took them down. Staff checked on each resident at least every hour. Door sensors were also implemented. Resident #174 had behaviors of verbal and physical aggression and was sexually inappropriate at times. The resident attended a lot of supervised activities. Resident #174 did not like other residents in their room and pushed them when they entered. Resident #174 removed barriers that staff put across their doorway to deter others from entering. Staff encouraged Resident #174's door to be closed until Resident #213 was found in the room in inappropriate manners. Resident #114 sustained a fractured hip when Resident #174 pushed them in their room. Resident #174 admitted to pushing the resident. The Manager thought that was the first time Resident #174 was physically aggressive with another resident. Staff attempted to supervise Resident #174 and their room but could not always be in the hallways as they had to provide resident care. Resident #174 now had a door sensor to alert staff that someone was going in or out of their room. Resident #174 was impulsive in the moment and quickly reverted to calmness post incident. Behavioral interventions were discussed as needed as an interdisciplinary team during morning reports. During an interview on 3/21/2024 at 3:53 PM, the Director of Nursing stated when there were resident-to-resident interactions on the dementia unit, they expected staff to use a lot of activities, keep residents in sight as much possible, engage the resident, and constant rounds when providing care. Staff were expected to redirect each resident before an incident could occur. Alarms were to alert staff of a potential situation and nurses were usually in the hallway giving medications. Staff were not able to be in the hallway at all times. Behavioral interventions were in the care plan and care instructions. Resident #114 broke their hip when they entered Resident #174's room and was pushed. That could have been prevented if staff saw Resident #114 ambulating on the unit and enter the room. Resident #191 sustained an abrasion when they were pushed and hit their head while in Resident #174's room. The incidents with Resident #174 and Resident #213 could have been prevented if staff saw them together prior to being inappropriate. In each instance, the residents were placed on hourly checks for 72 hours. Resident #213 was moved to a different unit to prevent reoccurrences. During an interview on 3/21/2024 at 4:41 PM, physician #4 stated Resident #114 sustained harm of a fractured hip and Resident #191 sustained an abrasion when they were pushed by Resident #174. 10 NYCRR 483.25(d)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 48895 Based on observation, record review, and interview during the recertification survey conducted 3/18/2024 -3/29/2024, the facility did not ensure parenteral fluids (delivery of fluid or medication through a vein) were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 resident (Resident #207) reviewed. Specifically, Resident #207 had an intravenous access device, the physician orders did not include the length of the external catheter or directions for measuring the catheter (to ensure it did not migrate or dislodge); licensed nurses did not know the type of the catheter the resident had; documentation of catheter care was inconsistent; and the care plan did not include daily care and monitoring of the device. Additionally, deficiencies related to intravenous therapy were identified in the areas of Significant Medication Errors (F760), and Competent Nursing Staff (F726). Findings include: The facility policy Intravenous Therapy - Monitoring and General Protocols revised 8/24/2023 documents all midline catheters will be evaluated for length of the external catheter and mid-arm circumference upon admission, and as needed. Documentation of measurements in [centimeters] will be in the electronic treatment administration record. Peripheral [intravenous] site needs to be changed when clinically indicated, every 7 days, or as ordered by the physician. A new sterile cap will be applied to the end of tubing and needleless connector when not in use. The facility policy Intravenous - Dressing Change for Central Vascular Access Devices and Midline Peripheral Catheter revised 8/23/2023 documents measure/note length of external catheter for all midlines, measure in [centimeters]. Measure from the hub of the catheter to insertion site of the catheter. Compare measurement to documented length of external catheter at time of insertion and/or most recent measurement. If there is a difference in measurements of the external catheter, contact physician to obtain order for chest x-ray to confirm the current tip location. Document measurements and procedures in the electronic treatment administration record; document observation and tolerance to the procedure in the progress notes. Resident #207 had diagnoses including pneumonia and sepsis (system wide infection). The 2/3/2024 Minimum Data Set assessment documented the resident was cognitively intact, required maximum assistance for activities of daily living, did not receive intravenous medications, and did not have intravenous access including peripheral, midline, or central lines. The 3/19/2024 discharge Minimum Data Set assessment documented the resident had a peripheral intravenous access and received intravenous antibiotics on admission and at discharge. The 3/13/2024 hospital discharge summary documented the resident was being discharged and would continue intravenous antibiotic therapy with ceftriaxone 2 grams daily until 3/22/2024. The resident was being discharged with an AccuCath (an intravenous catheter) given their chronic kidney disease stage an intravenous peripherally inserted central catheter was indicated. The 3/13/2024 physician orders documented: (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- AccuCath in left forearm for intravenous antibiotics, monitor for signs and symptoms of infection every shift - change midline dressing weekly on Thursday with [special protective covering], measure line length weekly. - Sodium chloride flush intravenous solution 0.9%, intravenously use 10 milliliters every shift to maintain intravenous patency for 9 days. - Arm circumference 10 centimeters above insertions site measured every Thursday. The comprehensive care plan initiated 3/11/2024 and revised 3/13/2024 documented the resident had a history of pneumonia. Interventions included to administer medications as ordered. A revision on 3/13/2024 documented a complicated urinary tract infection with interventions of ceftriaxone 2 grams (antibiotic) for 9 days, encourage fluids, administer antibiotic, monitor intake and output, monitor labs and diagnostics. A revision on 3/18/2024 documented the resident had respiratory syncytial virus (respiratory disease) with interventions including use of antibiotics. The comprehensive care plan did not include the use of intravenous fluids, intravenous medications, or the presence of an active intravenous access device. The 3/13/2024 health status note by licensed practical nurse #48 documented the resident was readmitted to the facility with a diagnosis of sepsis (systemic infection) secondary to urinary tract infection. The peripheral intravenous access device in the left forearm was patent and working and there were no signs or symptoms of infection at the insertion site. Intravenous ceftriaxone 2 grams was administered and was tolerated well. There was no documented evidence of a measurement of the external catheter length. The 3/14/2024 nurse practitioner #40 re-admission progress note documented the resident was hospitalized from 3/7/2024 through 3/14/2024 with diagnoses of upper gastrointestinal bleed, acute kidney injury, and sepsis pneumonia. The infection specialist recommended ceftriaxone 2 grams intravenously for 2 weeks. The resident was discharged back to the facility to continue the intravenous ceftriaxone 2 grams for sepsis pneumonia. The 3/14/2024 registered nurse #49 progress note documented the peripheral intravenous access device in the left forearm was patent and working, and there were no signs and symptoms of infection at the insertion site. There was no documented evidence of a measurement of the external catheter length. The 3/2024 Medication Administration Record documented: - Change midline dressing weekly on Thursdays with antiseptic dressing, and measure line length weekly. On 3/14/2024 licensed practical nurse #29 documented 9. The documented 9 was associated with the 3/14/2024 progress note by licensed practical nurse #29's documentation of not applicable. - Measure arm circumference 10 centimeters above insertion site. On 3/14/2024 licensed practical nurse #29 documented 9. The documented 9 was associated with the 3/14/2024 progress note by licensed practical nurse #29's documentation of not applicable. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Intravenous catheter in left forearm, monitor for signs and symptoms of infection every shift and was documented as completed on every shift. The medication administration record did not include a reference measurement of the midline catheter. During an interview on 3/20/2024 at 10:55 AM, licensed practice nurse Clinical Care Coordinator #32 stated Resident #207 had specific intravenous access device supplies for the maintenance of their midline catheter with infused green caps (disinfecting cap that is placed at the end of a vascular access device, intended to reduce the risk for infection) for infection control. The green caps went on the intravenous tubing and the intravenous hub when disconnected. During a follow up interview on 3/21/2024 at 1:18 PM, the licensed practical nurse Clinical Care Coordinator #32 stated licensed practical nurses with the specific intravenous course training were allowed to handle and administer medications through midline catheters as the end of the venous access device did not extend past the resident's shoulder. Resident #207's intravenous catheter did not go past the shoulder, which meant it was in the licensed practical nurse's scope of practice to administer medications through the device. During an interview on 3/21/2024 at 5:09 PM, licensed practical nurse #31 stated they were not aware that Resident #207 had a midline catheter as their intravenous access device, as they could not manage midline catheters. The additional orders for changing the dressing, measuring the catheter, and the circumference of the arm was not done by a licensed practice nurse. During an interview on 3/28/2024 at 9:10 AM, registered nurse #30 stated they had accessed Resident #207's intravenous access device, and it was either a peripherally inserted central catheter or a midline catheter. The venous access device could be visually identified by the external purple hubs where the medication tubing could be connected, a standard peripheral intravenous access device did not have those hubs. Resident #207 had purple hubs on their catheter. They stated if they signed the medication administration record stating they flushed the catheter then they did it. They recalled going into the resident's room and flushing a midline catheter. Upon reviewing the medication administration record to date, the resident's midline catheter had not been measured, their arm circumference was not measured, and the dressing had not been changed since their readmission. Once the intravenous infusion was completed the catheter would be flushed and a green cap applied on the purple hub. The tubing should never be without a cap. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2024 at 10:18 AM, licensed practical nurse #29 stated Resident #207 had a standard peripheral intravenous access device. A type of intravenous catheter was the securing device. A midline catheter would be higher up on the arm; the resident's peripheral intravenous device was on the forearm. They could visually tell the difference between a peripheral device and a midline based on where it was located on the body. The gauge of the peripheral device should be in the orders. The licensed practical nurse was unable to find any documentation related to the intravenous device. The hospital discharge was 3/13/2024, therefore they assumed the intravenous insertion date was 3/13/2024. The resident had orders related to a midline catheter that was communicated was going to be discontinued because the resident did not have a midline catheter. They did not speak to a provider regarding the orders. They documented the orders were not applicable. Upon the resident's readmission, there were no assessments completed by a registered nurse, except for their wounds. Peripheral devices could be kept in place safely for at least 14 days, probably longer. The importance of monitoring an intravenous site was to watch for infection and infiltration. There was no information in the electronic medical record regarding the intravenous access device insertion date, gauge, or length of external catheter. During an interview on 3/28/2024 at 11:40 AM, licensed practical nurse #17 stated they physically saw Resident #207's intravenous access device. The stat lock (a peripherally inserted central catheter stabilization device, holds the intravenous device in place) was blue in color. The total length of the catheter was 36 centimeters total, and the hospital did not provide the external catheter length. The external length was supposed to be measured on 3/14/2024. The dressing for the intravenous device was supposed to be changed on 3/14/2024. A registered nurse needed to change the dressing, measure the external catheter, and measure 10 centimeters above the site, and measure the circumference of the resident's arm. Licensed practical nurse #48 observed the intravenous site when Resident #207 came back from the hospital. The nursing assessment in the electronic health record should be done by a registered nurse. During an interview on 3/28/2024 at 1:54 PM, licensed practical nurse Clinical Care Coordinator #32 stated they were responsible for initiating and updating residents' care plans. The Clinical Care Coordinators could initiate care plans. The resident had a care plan for the antibiotic for their urinary tract infection, but not the intravenous device. Resident #207 had their peripheral intravenous access device inserted on 3/11/2024. Resident #207 had their dressing change ordered once a week due to the antiseptic dressing. The dressing was ordered to be changed on 3/14/2024, but there was no progress note, so they were not sure why it was not completed. If the dressing was not changed the provider should be notified to get a new date and time. When the resident was readmitted licensed practical nurse #32 stated they did the admission assessment and initial progress note. The resident was a readmission, so nothing changed for them. Physical assessments could be done by a licensed practical nurse, but a registered nurse had to assess the wounds and skin. During an interview on 3/28/2024 at 4:16 PM, nurse practitioner #40 stated that the nurses should have called them for clarification of the intravenous access device. Nurse practitioner #40 was not sure if the resident had a midline or central line catheter device. There was a visual difference between a peripheral device and midline device. If the resident was planned for 2 weeks of intravenous antibiotics it would likely have been a midline or a peripherally inserted central catheter. The resident was ordered for dressing changes weekly, and they should have done. If the dressing changes were not completed as ordered, it would put the resident at risk for infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2024 at 4:47 PM, licensed practical nurse #48 stated they had completed the required intravenous course that allowed them to access intravenous devices. Resident #207 had an intravenous catheter which was a peripheral device. They thought that licensed practical nurse #32 called the hospital to verify the type of device but could not recall the date that was completed. The dressing change to the intravenous site should have been changed. If there was a question about the type of venous access device, the order should have been clarified. During an interview on 3/29/2024 at 10:18 AM, the Medical Director stated if the nursing staff was not sure if the resident had a peripheral intravenous device or a midline device, they expected to be notified for clarification. If a dressing change was ordered for an intravenous device, it should have been completed. During an interview on 3/29/2024 at 10:47 AM, the Director of Nursing stated that Clinical Care Coordinators of the units were responsible for initiating and updating care plans. The only registered nurses that were assigned a unit were the Clinical Care Coordinators, however, many of the Clinical Care Coordinators were licensed practical nurses. The Assistant Director of Nursing oversaw all the units in the facility and did wound staging and assessments. Licensed practical nurses could not assess; they could observe and document. Licensed practical nurses could initiate care plans. There was no documentation indicating that a registered nurse assessed Resident #207's intravenous access device. The licensed practical nurse Clinical Care Coordinator #32 did the complete body systems assessment upon Resident #207's return from the hospital. There was no documentation that a registered nurse followed up on the licensed practical nurse's assessment document. If the intravenous device was a peripheral device, the orders for the midline should have been clarified. If the device was a midline catheter, the external catheter should have been measured and documented. If the device was a peripheral catheter, the gauge needle should have been documented. For both types of intravenous devices, there should have been a note in the medical record about the insertion date. Peripheral devices needed to be changed based on the facility policy or a specific physician's order. The Director of Nursing stated they thought the policy was that peripheral devices had to be changed after 3 days. If there was no documentation, there was no confirmation if anyone clarified whether Resident #207 had a midline or a peripheral device. 10 NYCRR 415.12(k)(2)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37516 48895 Based on record review and interview during the recertification survey conducted 3/18/2024-3/29/2024, the facility did not ensure that licensed nurses had the appropriate competencies and skill sets necessary to provide nursing care and related services to assure residents safety and attain or maintain the highest practicable physical, mental and psychosocial well- being for each resident for 4 of 4 licensed nurses (licensed practical nurses #31, #45, #48, and registered nurse #51) reviewed. Specifically, licensed practical nurses #31, #45, #48 and registered nurse #51 did not receive routine competency evaluations that covered key skill-set areas including accessing venous access devices, vacuum assisted wound closure devices (wound VACs), hand hygiene, and medication administration. Deficiencies were identified in the areas of Parenteral/IV (intravenous) fluids (F694), Free from Significant Medication Errors (F760), Quality of Care (F684), and Infection Control (F880). Findings Include: The Facility Assessment for 2023 documented annual in-services and competencies were coordinated and scheduled monthly throughout the year. Licensed nurse competencies included person-centered care, medication administration, resident assessments, and caring for persons with dementia and mental health disorders. The facility training document Intravenous (IV)- Scope of Practice dated 1/2018 documented the purpose was to delineate the scope of practice to ensure a consistent knowledge base and demonstration of competency. Licensed practical nurses may perform basic [intravenous] maintenance if they had completed the intravenous maintenance course, demonstrated competency, and a registered nurse was present in the facility. The facility policy Staff Education dated 11/9/2018 documented staff would be provided ongoing educational opportunities that met requirements of the New York State Department of Health and that promoted the growth and reinforce procedures for the nursing home. All employees would be required to receive training upon hire at general orientation and annually on the topics of infection control, safety, resident rights, abuse, corporate compliance, dementia, and quality assurance. The undated facility training document The Practice of Intravenous Therapy by Licensed Practical Nurses in Acute Care Settings documented the provision of intravenous therapy by a licensed practical nurse must be under the direct supervision of a registered nurse who is assigned to the patient care unit at all times that the licensed practical nurse administers [intravenous] therapy. Nursing Personnel Records documented the most current annual competencies as follows: 1) Licensed practical nurse #48 had orientation competencies completed on 4/18/2023, there were no documented competencies for medication administration skills, administration through an intravenous access device, intravenous access device identification, or wound vacuums. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Point Rehabilitation and Nursing Center	3700 Old Vestal Road Vestal, NY 13850

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) Registered Nurse #51 had orientation competencies completed on 7/3/2023 and 7/5/2023, there were no documented competencies for administration through an intravenous access device, intravenous access device identification, or wound vacuums. 3) Licensed practical nurse #45 had orientation competencies completed on 2/5/2024, there were no documented competencies for administration through an intravenous access devices, intravenous access device identification, or wound vacuums. 4) Licensed Practical Nurse #31 did not have orientation competencies provided by the facility for handwashing, personal protective equipment, or medication administration. Additionally, they did not have documented competencies for administration through an intravenous access devices, intravenous access device identification, or wound vacuums. During an interview on 3/21/24 at 4:21 PM, licensed practical nurse Staff Development Coordinator #50 stated they provided education for all staff in the facility. They stated they had not done medication administration trainings or competencies. They were told by the previous Director of Nursing and Administrator that they did not have to do training due to a COVID waiver. They were not intravenous certified, and they did not provide competencies for intravenous medication administration. They would have to use a registered nurse to complete intravenous skills training. The administration reached out to licensed practical nurse #50 for all the competencies the nurses had on file. They stated that if it was not in the package provided, it did not exist. During an interview on 3/28/2024 at 9:10 AM, registered nurse #30 stated the facility offered a class through the pharmacy for intravenous knowledge, but registered nurse #30 had not experienced any competencies related to intravenous maintenance or medication administration by the education department in the facility. They clarified that competencies meant they were visually watched as they demonstrated the skills, that activity had not been done. During an interview on 3/28/2024 at 10:18 AM, licensed practical nurse #29 stated they were intravenous certified. They took the facility provided class twice, last year being the last class. Competencies were done at the end of class as part of the certification for intravenous access devices. The facility did in-services on medication administration but there were no competencies for medication administration. During an interview on 3/28/2024 at 1:54 PM, licensed practical nurse Clinical Care Coordinator #32 stated the facility had not done competencies since they returned to the facility in 7/2022. They had in-services, but competencies were not completed for the nursing staff. During an interview on 3/28/2024 at 3:42 PM, licensed practical nurse Staff Development Coordinator #50 stated that the facility had many agency staff. They provided orientation every other week on Mondays and Tuesdays. Staff nurses got 3 days of orientation, certified nurse aides got 2 days of orientation, and agency nurses got 1 day of orientation. The competencies that have a K next to competent on the checklists met they were competent by knowledge. Competent by knowledge met that the nurse or aide stated they knew the material and the processes were talked through. If they did the actual competencies, it would take 3 weeks to get through everything. If the competency was blank, but signed by licensed practical nurse #50, it documented it was competent by knowledge. There were no wound vac competencies or in-services. Handwashing was done during orientation, but no additional competencies were done. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/28/2024 at 4:47 PM, licensed practical nurse Nursing Supervisor #48 stated the facility did competencies when hired. Additionally, every time there was a medication error, they had to complete a competency for medication administration. The first time licensed nursing staff did an intravenous medications someone had to watch and there was a checklist for that. During an interview on 3/29/2024 at 10:47 AM, the Director of Nursing stated they could not recall the last time they had a nursing competency for medication administration. They were working on a plan to provide in-services and mandatory trainings. During an interview on 3/29/2024 at 12:19 PM, the Administrator stated that the orientation process and training tools were outdated. It was the Director of Nursing's responsibility to oversee the nurse and certified nurse aide competencies. The facility was conducting an in-service and orientation audit with a performance improvement plan. The Administrator stated there was a nurse that reviewed admission medications, and that pharmacy did consults that were reported to the Director of Nursing. There were no audits for medication administration on the units. 10 NYCRR 415.26(c)(1)(iv)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 37516 Based on record review and interview during the recertification survey conducted 3/18/2024-3/29/2024 the facility did not ensure certified nurse aide performance reviews were completed once every 12 months for 5 of 5 certified nurse aides (certified nurse aides #35, #41, #42, #43, and #44) reviewed. Specifically, there was no documented evidence certified nurse aides #35, #41, #42, #43, and #44 had performance reviews at least once every 12 months. Findings include: The facility policy titled Staff Evaluations, last modified 11/9/2018, documented the facility would provide ongoing feedback to all staff members regarding their performance at specific intervals to encourage continuous improvement as needed. All staff members would receive an annual performance evaluation. If there were any identified areas of weakness, they would be referred to staff education to address the identified areas and assist with performance improvement. Annual performance evaluations were documented as follows: - Certified nurse aide #35: 1/2/2022. - Certified nurse aide #41: 12/29/2021. - Certified nurse aide #42: 1/2/2022. - Certified nurse aide #43: 2/22/2023. - Certified nurse aide #44: 2/17/2023. There was no documented evidence certified nurse aides #35, #41, #42, #43, and #44 had annual performance evaluations since the above noted dates. During the quality assurance interview on 3/29/2024 at 12:17 PM the Administrator stated the Director of Nursing oversaw all the nursing department evaluations and nursing disciplinary actions. During a follow-up interview on 3/29/24 at 1:20 PM the Administrator stated per regulation, certified nurse aides were required to have 12 hours of in-service training annually, with an annual performance evaluation and in-services based on their evaluation deficiencies. During an interview on 3/29/2024 at 1:42 PM certified nurse aide #46 stated they did not know what a performance evaluation meant. They did not recall anyone evaluating them specific to their job. During an interview on 3/29/2024 at 1:47 PM certified nurse aide #35 stated their last performance evaluation was at least a year-and-a-half ago. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/29/2024 at 1:55 PM certified nurse aide #47 stated they used to have annual performance evaluations but had not had any since the COVID pandemic. It had been at least a couple of years since their last annual performance evaluation. During an interview on 3/29/2024 at 2:07 PM the Assistant Director of Nursing stated the certified nurse aide annual performance evaluations were done by the Clinical Care Coordinators (Nurse Managers) on the units. Most of the Clinical Care Coordinators were licensed practical nurses. During an interview on 3/29/2024 at 2:12 PM the Director of Nursing stated the Personnel Coordinator tracked and let Clinical Care Coordinators know when certified nurse aides were due for their annual performance evaluations. They did annual performance evaluations on Nurse Managers, Supervisors, and ancillary staff. They were aware that certified nurse aide performance evaluations were not getting done as required. 10 NYCRR 415.26 (d) (7)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 48895 Based on observation, record review, and interview during the recertification and abbreviated (NY00328316) surveys conducted 3/18/2024-3/29/2024, the facility failed to ensure that residents were free of any significant medication errors for 1 of 1 resident (Resident #207) reviewed. Specifically, Resident #207 was given an incomplete dose of an intravenous antibiotic, 1 late administration of an intravenous antibiotic, and the intravenous access site was not flushed as ordered. Additionally, deficiencies in quality of care related to parenteral/intravenous fluids, and competent nurse staffing were identified in the areas of Parenteral/IV fluids (F694), and Competent Nursing Staff (F726). Findings include: The facility policy Medication Administration System revised 11/10/2020 documented all medication orders are checked against the [electronic medication administration record] and the physician's order in the electronic medical record before administering any drugs the first time. A nurse is responsible for questioning a drug order, if, in their judgment the order is in error or if the order is not legible. At the end of each period of passing medication, the nurse would review the electronic medication administration record for accuracy and completeness, any blank spaces found constitutes a medication error. Drug errors were to be reported immediately to the nursing supervisor and attending physician. The facility policy Intravenous Therapy - Monitoring and General Protocols revised 8/24/2024 documented all physician orders for intravenous therapy would include the route; specific fluid; medication; flush solution, including amount and frequency; volume/flow rate for [intravenous] therapy; and total length of time. Rates will include the amount to be infused per column to time. A new sterile cap was applied to the end of tubing and needleless connector when not in use. All peripheral lines were to be flushed per physician orders and documented in the electronic medication administration record. Resident #207 had diagnoses including pneumonia and sepsis. The 3/19/2024 discharge Minimum Data Set documented the resident was receiving intravenous antibiotics; had peripheral intravenous access upon this admission and at discharge. The comprehensive care plan initiated 3/11/2024 and revised 3/13/2024 documented a history of pneumonia. Interventions included administer medication as ordered, and provide oxygen as needed. The comprehensive care plan revised 3/13/2024 documented a complicated urinary tract infection. The interventions included ceftriaxone 2 grams (antibiotic, did not specify intravenous or oral) for 9 days, encourage fluids, administer antibiotic, monitor intake and output, monitor labs and diagnostics. The comprehensive care plan revised 3/18/2024 documented respiratory syncytial virus (respiratory disease affecting the lungs). The interventions included use of antibiotics. There was no comprehensive care plan for the use of intravenous fluids, intravenous medications, or active intravenous access device. The 3/13/2024 nurse practitioner #15's order documented: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- ceftriaxone sodium 2 grams, intravenously every 24 hours for infection/sepsis/urinary tract infection for 9 days at 8:00 PM with sodium chloride flush intravenously before and after antibiotic administration. - sodium chloride flush intravenous solution 0.9%, intravenously use 10 milliliters every shift to maintain intravenous patency for 9 days. - intravascular catheter in left forearm, monitor for sign and symptoms of infection, every shift for antibiotic. During an observation on 3/18/2024 at 10:19 AM, 1:55 PM, and 2:41 PM, there was an intravenous pole with a medication pump in Resident #207's room. There was a quarter full medication bag hanging on the intravenous pole. The intravenous tubing in the pump had the end of the tubing looped over the pump without an infection prevention cap. The 3/2024 Medication Administration Record documented ceftriaxone 2 grams intravenously every 24 hours for infection/sepsis/urinary tract infection for 9 days with a start date of 3/13/2024: - ceftriaxone was documented as administered by licensed practical nurse #54 on 3/16/2024 at 11:16 PM, more than 24 hours after the dose was administered on 3/15/2024 at 8:34 PM. - ceftriaxone was documented as administered by licensed practical nurse #31 on 3/17/2024 at 8:51 PM. The next dose on 3/18/2024 was due between 7:51 PM- 9:51 PM on 3/18/2024. The 3/2024 Medication Administration Record documented sodium chloride flush intravenous solution 0.9%, use 10 milliliters intravenously every shift to maintain intravenous access device patency for 9 days with a start date of 3/13/2024. - On 3/15/2024, there was no documentation the sodium chloride flush was administered to the resident's intravenous access device on the day shift. During an interview on 3/20/2024 at 10:55 AM, licensed practical nurse Clinical Care Coordinator #32 stated there should not be any medication left in the intravenous medication bag the next morning after the medication was given, especially if the tubing was disconnected. All medications should be disposed of after use. The pharmacy sent Resident #207's medications with instructions to administer 100 milliliters over 30 minutes. It was important for the resident to receive all the medication from the intravenous medication bag because the lack of medication could cause ineffectiveness. The physician order should include the flow rate/infusion time, but the pharmacy added the instructions to the bag. During a follow up interview on 3/21/2024 at 1:18 PM, licensed practical nurse Clinical Care Coordinator #32 stated Resident #207 had an AccuCath (an intravenous access device), which was a midline catheter and a peripheral venous access device. There was no location to document the medication completion time. The medication was administered over 30 minutes with a flush before and after. The flushes were listed together and only required one administration of the flush to be completed in the medication administration record. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/2024 at 5:09 PM, licensed practical nurse #31 stated that an intravenous antibiotic order needed to include the flush, the flow rate/infusion time, and strength. If the order was incomplete, they would call the supervisor or whoever took the order, then call the provider to get clarification. The process for the resident's intravenous medication administration was to flush the intravenous access device with 10 milliliters and check the administration button which triggered the check mark and their initials on the medication administration record, administer the medication, when it was done, they would flush the intravenous access device again. There should not be any medication remaining in the bag when the medication was done infusing. They administered Resident #207's intravenous antibiotic on 3/17/2024 but had the nursing Supervisor assist them. On 3/18/2024, they had assistance from licensed practical nurse #48. Failure to give a full dose of the antibiotic could cause the infection to come back stronger. Licensed practical nurse #31 stated they threw the medication bag away when it was done and thought they had thrown away the medication bag on the night of 3/17/2024. Upon viewing the order in the computer, licensed practical nurse #31 stated the order was incomplete and did not have a flow rate/infusion time. They stated they used the intravenous pump library (saved data from previous administrations) to administer the antibiotics. The registered nurses were responsible for setting up the pumps with the library on their first administration. Licensed practical nurse #31 stated they should have checked the medication, order, and pump together to make sure they all matched. During an interview on 3/22/2024 at 11:11 AM, the Assistant Director of Nursing stated that an order for an intravenous medication should include a flow rate/infusion time. There should not be any medication remaining in the administration bag when the infusion was complete, so the full dose was administrated to the resident. If there was medication remaining in the bag 12 hours after the medication was infused, this would be a medication error and the provider should be notified. If Resident #207 did not receive the full dose of the antibiotic this could be harmful to the resident. During an interview on 3/28/2024 at 9:10 AM, registered nurse #30 stated that a complete infusion of an intravenous antibiotic would mean the medication bag was empty. If medication remained in the bag, it would be considered a medication error. The facility policy was to administer medications in the window of 1 hour before the due time, to 1 hour after the due time. Registered nurse #30 stated they would consider the 3/16/2024 dose a medication error as it was given more than 2 hours past the medication administration window. The latest time the medication should be given would be 9:00 PM. The combination of late medications and incomplete infusions would be considered a significant medication error. This could cause the resident to be more susceptible to infection. During a telephone interview on 3/28/2024 at 12:07 PM, intravenous technician #28 stated that the physician orders should have an infusion rate. Their office had to call the provider to clarify the order. The pharmacy included directions to infuse total contents on the intravenous medications. If a medication was due to be given at 8:00 PM, the nurses had an hour before and an hour after to administer that medication. For a medication given at 11:16 PM, the next dose should have been re-timed to 11:16 PM the following day. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 3/28/2024 at 1:54 PM, licensed practical nurse Clinical Care Coordinator #32 reviewed Resident #207's Medication Administration Record and stated Resident #207 did not receive all the intravenous flushes every shift as ordered, as 3/15/2024 on the day shift was missing and it should have been done. The antibiotic on 3/16/2024 was given late, as there was a 1 hour before and 1 hour after the ordered administration time to give the medication, this was a medication error. The partial dose given to the resident on 3/17/2024, was also a medication error. They were unaware of any errors with Resident #207's medication administrations. During an interview on 3/28/2024 at 4:16 PM, nurse practitioner #40 stated intravenous antibiotics were an aggressive treatment, and infusion rates should always be included in the order, if not the nurses should contact the provider for clarification. If medication was given more than 2 hours late, or if the resident received a partial dose of the intravenous antibiotic, they expected to be notified. If the resident did not receive their full dose of antibiotic this could put the resident at risk of infection. Nurse practitioner #40 stated they had not been notified of any late or partial doses of antibiotic for Resident #207. The antibiotic was ordered to treat the infection. There could be risk of increased infection if the infection went untreated. During an interview on 3/28/2024 at 4:47 PM, licensed practical nurse #48 stated they assisted licensed practical nurse #31 with the resident's intravenous administration as they were newer at intravenous administration. Resident #207 did not have an infusion rate in their order, therefore was no way to verify the medication. This was a medication error. As a supervisor, they would notify the provider. The additional dose given at 11:16 PM on 3/16/2024 was also a medication error. The provider should have been notified and the following medication administration times should have adjusted. The late dose and partial dose could cause the infection to worsen, and the late dose could cause the next dose to be given too soon. During an interview on 3/29/2024 at 10:18 AM, the Medical Director stated that medication orders should include infusion time/flow rate, it was expected that they would reach out to the provider for clarification. If the antibiotic was given more than 2 hours late or the dose was incomplete, they should be notified. The late dose and partial dose were both medication errors and staff should have notified them, and they did not. During an interview on 3/29/2024 at 10:47 AM, the Director of Nursing stated Resident #207 did not receive their intravenous flushes per physician orders, as they missed a dose on 3/15/2024. Resident #207's intravenous antibiotic was not given timely and accurately according to the physician orders, the dose on 3/16/2024 was out of that range for administration. The provider should have been notified, there should have been a progress note to go along with that communication, and there was not. Based on the lack of documentation, the nursing staff did not get clarification from the provider to give the dose late, and this was a medication error. An incomplete dose of a medication would also be a medication error, and the provider should have been notified. 10 NYCRR 415.12(m)(2)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 35045 Based on record review and interviews during the recertification survey conducted 3/18/2024-3/29/2024 the facility's governing body did not establish and implement policies regarding the management and operation of the facility. Specifically, there was not consistent communication between the governing body and the facility Administrator to ensure regulatory compliance. Multiple deficiencies including an immediate jeopardy in Influenza and Pneumococcal Immunizations (F883) were identified during the recertification survey. Findings include: The undated facility policy Quality Assurance Performance Improvement Committee (QAPI) Plan documented: - Quality assurance performance improvement addresses clinical care to continuously improve clinical care. Care data would be reviewed by the committee to proactively identify areas in need of improvement; and address resident choice to ensure decisions affecting the residents were made based on individual preference and care needs. - Administration is responsible for guiding and participating in the quality assurance performance improvement committee. - A member of the facility Advisory Board is committed to participating in the committee and providing a status report at the monthly Advisory Board Meeting. - The Committee will evaluate the program on a quarterly basis, and this will include ensuring that there are adequate resources allotted to meet their initiatives and goals. - A member of the facility Advisory Board will be designated as a liaison to the committee. The individual is vested with the responsibility to report ongoing quality assurance updates to the Advisory Board monthly. Refer to F 883 citation Influenza and Pneumococcal Vaccinations An electronic mail chain dated 1/23/2024 (1 month and 3 weeks after the pneumococcal vaccine request was made) documented: - At 11:17 AM, from the Infection Preventionist to the Deputy Administrator of Fiscal questioning where the pneumococcal vaccine purchase order was as they had many pending vaccinations to give. - At 11:51 AM, the Deputy Administrator of Fiscal responded to the facility accountant asking if the request was the same, they had questioned the pricing. - At 11:53 AM, the facility accountant responded: yes, it was over $10,000. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	- At 11:59 AM, the Deputy Administrator of Fiscal to the keyboard specialist the vaccine order was sent back due to it being over $10,000. It would need to be a state contract or group purchasing contract if exceeding $10,000. During an interview on 3/25/2024 at 11:08 AM, the Assistant Director of Nursing stated the Deputy Administrator was responsible for approval of supply costs. They stated if requested supplies were under a certain dollar amount the facility would cover the cost. If they went over that dollar amount, they had to go to fiscal for approval. During an interview on 3/25/2024 at 2:07 PM, the Administrator stated their Infection Preventionist put in a purchase request for the pneumococcal vaccinations and was told that anything over $10,000.00 needed to go to the legislature and that took approximately 2 months. On 3/24/2024 they authorized the payment for the vaccines without the Deputy Administrator of Fiscal approval. They told the pharmacy to charge it to their personal credit card and they would just submit an expense report later. In June of 2023 the Deputy Administrator of Fiscal should have told the Infection Preventionist how to order vaccines and methods to keep the cost below $10,000. They had recently notified the current Deputy Administrator of Fiscal that purchases for clinical health products should now go through the Administrator. During an interview on 3/25/2024 at 3:17 PM, the Deputy Administrator of Fiscal Services stated they must follow the purchasing rules of the county. They sent the Infection Preventionist a listing of groups they could order vaccinations from. Nursing put in the request for vaccines which went to the county office building. The county office reviewed the request, and they would either approve or deny via an electronic mail and would deny the request if it was over $10,000.00. 10NYCRR 415.26(b)(3)(1) 37516

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	335291	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Point Rehabilitation and Nursing Center	3700 Old Vestal Road Vestal, NY 13850

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48632 Based on observation and interview during the recertification and abbreviated (NY00311514) surveys conducted 3/18/2024-3/29/2024 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 4 of 5 residents (Residents #3, #147, #195, and #212). Specifically, licensed practical nurse #45 did not perform hand hygiene between medication administrations to Residents #3, #147, #195, and #212. (Refer to F 726 Competent Nursing Staff). Findings include: The facility policy Medication Administration System last modified 11/20/2020 documented nurses perform hand hygiene immediately before preparing medications. The facility policy Hand Hygiene last modified 7/29/2020 documented hand hygiene is done before and after any contact with residents, after handling trash, after handling soiled linen or supplies, before and after personal care, before and after feeding residents, and after restroom use. Hand hygiene also applies when administering medications. The following observations were made on 3/20/2024 during a medication administration with licensed practical nurse #45: - at 9:36 AM, licensed practical nurse #45 began preparing medications for Resident #147. Medications included Celexa (antidepressant), senna plus (laxative), and artificial tears (eye drops). Licensed practical nurse #45 entered the resident's room and administered the resident's eye drops and the pills. Licensed practical nurse #45 returned to the medication cart signed off the medications as administered, and handled their pen and personal clipboard on top of the medication cart, and did not perform hand hygiene. - at 9:43 AM, licensed practical nurse #45 moved the medication cart near Resident #195's room, did not perform hand hygiene and prepared Resident #195's medications including atenolol (blood pressure medication), vitamin D3, Eliquis (blood thinner), Lasix (diuretic), fiber laxative, eye vitamin, and spironolactone (blood pressure medication). Licensed practical nurse #45 entered the resident's room, administered the medications, and returned to the medication cart, signed for the medications, handled their pen and clipboard, and did not perform hand hygiene. - at 9:51 AM, licensed practical nurse #45 moved the medication cart near Resident #45's room, did not perform hand hygiene and prepared Resident #45's medications including acidophilus (probiotic), (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amlodipine (blood pressure), Labetalol (blood pressure medication), Keppra (seizure medications), Protonix (treats reflux), hydralazine (blood pressure medication), Vitamin D3, baclofen (muscle relaxant), folic acid (supplement), ramipril (blood pressure medication), and sertraline (antidepressant). Licensed practical nurse #45 entered the resident's room, administered the medications, and returned to the medication cart, signed for the medications, handled their pen and clipboard, and did not perform hand hygiene. - at 10:06 AM, licensed practical nurse #45 moved the medication cart near Resident #3's room, did not perform hand hygiene and prepared Resident #3's medications including artificial tears drops, aspirin, Sinemet (treats tremors), cranberry supplement, Enulose (laxative), Keppra (seizure medication), metoprolol (blood pressure medication), Toujeo 8 units insulin injection, venlafaxine (antidepressant), and esomeprazole magnesium (acid reducer). The medications were crushed. Licensed practical nurse #45 entered the resident's room and administered the insulin in the resident's right upper arm. Licensed practical nurse #45 spooned the medications to the resident with vanilla pudding alternating with nectar thick juice. They exited the resident's room, signed off administration, handled their pen and personal clipboard, and did not sanitize their hands. Licensed practical nurse #45 did not perform hand hygiene from 9:36 AM- 10:06 AM while administering medications. During an interview on 3/20/2024 at 10:26 AM licensed practical nurse #45 stated they had sanitizer and pointed to the left side of the medication cart. They stated they did not use it in between these 4 residents and should have. If they did not have clean hands, they could pass germs between residents. During an interview on 3/22/2024 at 8:39 AM licensed practical nurse Infection Preventionist #5 stated during medication administration nurses should wash their hands or use hand sanitizer between all residents and before and after giving eye drops and known exposure to soiled items. Lack of proper hand hygiene could cause sickness. Hand washing was the number one way to stop the spread of infection. 10 NYCRR 483.80 (a)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Develop and implement policies and procedures for flu and pneumonia vaccinations. 35045 Based on record review and interview during the recertification survey conducted 3/18/2024-3/29/2024, the facility failed to vaccinate eligible residents with the pneumococcal vaccination (a vaccination developed to minimize the risk of acquiring, transmitting, or experiencing complications of pneumonia) for 44 of 245 residents who consented to the pneumococcal vaccine. Specifically, from 9/5/2023 through 3/25/2024, Residents #12, #14, #17, #18, #24, #27, #31, #43, #45, #57, #63, #74, #82, #95, #102, #103, #108, #109, #117, #118, #126, #129, #134, #165, #173, #177, #186, #192, #213, #214, #215, #216, #219, #222, #224, #226, #229, #235, #484, #533, #585, #586, #587, and #633 consented to and had medical orders to receive the pneumococcal vaccine and did not receive it. Subsequently, 7 of the 44 residents (Resident #24, #95, #109, #126, #215, #229, and #484) were diagnosed with pneumonia and one resident (Resident #95) was hospitalized twice for the treatment of pneumonia. Additionally, a request to purchase the pneumococcal vaccine was submitted by the Director of Nursing and was denied by the fiscal officer; and the Medical Director was not notified the vaccine was not available. This placed 44 residents at the facility at risk for serious harm or death that was Immediate Jeopardy. Findings include: The facility policy Purchase Order Expenditures revised 8/12/2019 documented the requesting department sends a completed Departmental Purchase Request Form or a facility Blanket Purchase Order Encumbrance Request form to fiscal along with any backup from vendors. All paperwork is given to the Deputy of Fiscal to initial and approve. The facility policy EMR (Electronic Medical Record)-Physician/Nurse Practitioner/Physician Assistant Orders updated 1/2019 documented nursing staff would process new, renewed, revised, or discontinued medication, treatment, and ancillary orders provided by the physician/nurse practitioner/physician assistant using the electronic medical record. The facility policy Physician Calls updated 2/2009 documented physician should be notified of changes to include but not limited to change in resident's condition, a resident fall, accident and/or incident to verify orders, and clarification of orders. The facility policy Standing Orders for Administering Pneumococcal Vaccines to Nursing Home Residents dated 9/2022 documented standing orders from the Medical Director to administer pneumococcal vaccines to consenting adult nursing home residents enable nurses to assess the need for vaccination and to vaccinate consenting adults. The procedure included assess adults for need of vaccination; screen for contraindications and precautions; provide vaccine information statements and obtained signed informed consent; administer pneumococcal vaccine; document the dose, date, time, the site the vaccination was given, the lot number, expiration date, and the brand of the vaccine administered. A 12/5/2023 supplier order summary documented 4 boxes of pneumococcal vaccine 0.5 milliliter unit doses (10 count= 40 doses) with an estimated total of $10,158.56. The items were in stock, and the facility could receive the order by the following day. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A 12/6/2023 facility Request Form for Departmental Purchase Order documented the Nursing Department requested 4 boxes of pneumococcal vaccine for a cost of $10,158.56. The order was needed as soon as possible for resident and staff immunizations. The form was signed for approval by the Administrator and Assistant Director of Nursing. The form documented after approval, send to Fiscal Department. An electronic mail chain dated 1/23/2024 (1 month and 3 weeks later) documented: - At 11:17 AM, from Infection Preventionist/licensed practical nurse to the Deputy Administrator of Fiscal, questioning where the pneumococcal vaccine purchase order was as they had a lot of pending vaccinations to give. - At 11:51 AM, the Deputy Administrator of Fiscal responded to the facility accountant asking if the request was the same, they had questioned the pricing. - At 11:53 AM, the facility accountant responded, yes it was over $10,000. - At 11:59 AM, the Deputy Administrator of Fiscal to keyboard specialist, the vaccine order was sent back due to it being over $10,000. It would need to be a state contract or group purchasing contract if exceeding $10,000. Residents #12, #14, #17, #18, #24, #27, #31, #43, #45, #57, #63, #74, #82, #95, #102, #103, #108, #109, #117, #118, #126, #129, #134, #165, #173, #177, #186, #192, #213, #214, #215, # 216, #219, #222, #224, #226, #229, #235, #484, #533, #585, #586, #587, and #633 signed consent forms and had medical orders to receive the pneumococcal vaccine. There was no documented evidence they received the vaccine as ordered. Resident #95 had diagnoses including pneumonia and diabetes. The 12/5/2023 Minimum Data Set documented the resident was cognitively intact, and the pneumococcal vaccine was not up to date and the pneumococcal vaccine was not received because it was not offered. A 11/29/2023 physician order documented pneumovax (pneumococcal vaccine) as indicated. A facility pneumococcal conjugate vaccine consent form dated and signed by the resident's representative and witnessed by a nurse (illegible signature) on 12/13/2023 documented the resident wished to receive the pneumococcal vaccine. The November and December 2023 and January, February, and March 2024 medication administration records did not include orders for the pneumococcal vaccine or administration of the vaccine. A 1/24/2024 at 6:13 PM licensed practical nurse #52 progress note documented the resident was experiencing shortness of breath and shaking all over. Oxygen was increased to 5 liters per minute and oxygen saturation (amount of oxygen carried in blood) would not go above 76%. The on call physician was notified and ordered the resident be sent to the hospital. The resident was transported to the hospital by emergency medical services. A 1/25/2024 at 5:14 AM, licensed practical nurse #12 progress note documented the resident was admitted to the hospital for pneumonia. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	A 1/25/2024 at 2:32 PM licensed practical nurse #38 progress note documented the resident returned from the hospital and was receiving antibiotics for pneumonia. A 2/23/2024 at 7:27 PM licensed practical nurse #11's progress note documented the resident was experiencing tremors. Their oxygen saturation was 77% and their temperature was 102 degrees Fahrenheit. The attending physician was notified, and the family requested the resident be sent to the hospital. 911 was called and the resident was sent to the hospital. A 2/24/2024 at 3:04 AM licensed practical nurse #53 progress note documented they were informed by the hospital the resident was admitted for pneumonia. A 3/1/2024 nurse practitioner #13 progress note documented the resident was seen for a readmission visit after they were admitted to hospital for institutional acquired pneumonia and was started on intravenous antibiotics. The 3/7/2024 at 10:53 AM, licensed practical nurse #11's nursing progress note documented the resident was readmitted to the facility with a diagnosis of pneumonia. Resident #215 had diagnoses including congestive heart failure, chronic obstructive pulmonary disease (lung disease), and chronic respiratory failure. The 10/23/2023 Minimum Data Set documented the resident was cognitively intact, their pneumococcal vaccine was not up to date, and the vaccine was not offered. A facility pneumococcal conjugate vaccine consent form dated and signed by the resident and witnessed by a nurse (illegible signature) on 10/16/2023 documented the resident wished to receive the pneumococcal vaccine. A 10/16/2023 physician order documented pneumovax as indicated. The October, November and December 2023 and January and February 2024 Medication Administration Records did not include orders for the pneumococcal vaccine or administration of the vaccine. A 2/18/2024 at 7:44 PM licensed practical nurse #16 progress note documented the resident was on droplet precautions and was receiving antibiotics for pneumonia. A 2/21/2024 nurse practitioner #20 progress note documented the resident was seen for a routine follow up after they were treated for respiratory syncytial virus [RSV] (a respiratory virus) with superimposed pneumonia and was started on an antibiotic on 2/18/2024. The March 2024 medication administration record documented pneumococcal vaccine inject intramuscularly one time only, administer upon arrival from the pharmacy with a start date of 3/20/2024. On 3/23/2024 at 11:31 AM licensed practical nurse #14 documented with a code 9- other /see progress note. Licensed practical nurse #14's progress note documented pneumococcal vaccine was to be administered upon arrival from the pharmacy. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview on 3/25/2024 at 3:16 PM, Resident #215 stated they recalled consenting for the pneumococcal vaccine, and they always took any available vaccines. They were concerned about dying. They felt the pneumococcal vaccine would help them because they required oxygen every day and had a history of bronchitis. Resident #126 had diagnoses including dementia, heart disease, and history of pulmonary embolism (blood clot that blocks blood flow to the lung). The 11/15/2023 readmission Minimum Data Set documented the resident was cognitively intact, the pneumococcal vaccine was not up to date, and was not offered. A facility pneumococcal conjugate vaccine consent form dated and signed by the resident and witnessed by a nurse (illegible signature) on 9/27/2023 documented the resident wished to receive the pneumococcal vaccine. A facility pneumococcal conjugate vaccine consent form dated and signed by the resident's representative (Health Care Proxy) and witnessed by a nurse (illegible signature) on 11/9/2023 documented the resident wished to receive the pneumococcal vaccine. A physician order dated 11/9/2023 documented pneumococcal vaccine as indicated. The November, December 2023 and January, February 2024 medication administration record did not have documented orders for the pneumococcal vaccine or that it was administered. A 2/5/2024 nurse practitioner #15 progress note documented the resident had respiratory viral testing completed and was found to have underlying pneumonia and was treated with antibiotics. The March 2024 medication administration record documented pneumococcal vaccine inject intramuscularly one time only, administer upon arrival from the pharmacy with a start date of 3/20/2024. On 3/21/2024 at 12:04 AM registered nurse #3 documented 9- other/see progress note. Registered nurse #3's progress note documented the vaccine was on order and had not been delivered from the pharmacy. During an interview on 3/25/24 at 2:45 PM, Resident #126's spouse and health care proxy stated Resident #126 had pneumonia in January or February 2024. They wanted the pneumonia shot and could not recall signing a consent for the pneumonia vaccine. INTERVIEWS: During an interview on 3/20/2024 at 12:02 PM, licensed practical nurse/Infection Preventionist #5 stated the pneumococcal vaccine needed to be ordered. There were over 10 residents that had consents for pneumococcal vaccine but there were no vaccines available in the facility. There were issues with a vaccine shortage due to cost in October 2023. They spoke to the Deputy Administrator of Fiscal in January 2024 via electronic mail and again today via telephone and they were still working on contract pricing for the pneumococcal vaccines. During an additional interview on 3/22/2024 at 8:39 AM, licensed practical nurse/Infection Preventionist #5 stated they were responsible for all vaccines for staff and residents. They could not recall the exact date they ran out of the pneumococcal vaccine, but it was prior to September 2023. They had 45 residents with pneumococcal vaccine consents that did not receive the vaccine. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview on 3/25/24 at 11:08 AM, the Assistant Director of Nursing stated the pneumococcal vaccine was not available for the residents. They had not received it from the pharmacy but were scheduled to receive it later this day. The Fiscal department rejected the cost of the vaccines, and the ball was dropped due to poor communication. They stated they were responsible for ordering the vaccine, but they could not approve the cost of anything. During a follow-up interview on 3/25/2024 at 11:10 AM, licensed practical nurse/Infection Preventionist #5 stated residents consented to vaccines and their immunization record was updated in their medical record. The vaccines were standing orders that were signed by the Medical Director. They ordered the vaccines on December 6, 2023, and were not able to get them due to the cost. Residents were more susceptible to pneumonia and could have negative health impacts due to their medical diagnoses. The vaccine was recommended for the residents. The pneumococcal vaccine could protect them but did not prevent the illness. During an interview on 3/25/2024 at 11:13 AM, Administrator #1 stated they had a new Deputy Administrator of Fiscal who made the request for the pneumococcal vaccinations, but the County could take a long time to approve anything. The Administrator stated they just approved the pneumococcal vaccines at a cost of $10, 897.30 and it would be delivered from the pharmacy today. They stated nobody really knows what could happen if a resident did not receive the pneumococcal vaccination, and they had residents who were diagnosed with pneumonia. During a telephone interview on 3/25/2024 at 11:15 AM, the Medical Director stated the infection control nurse was responsible for keeping them up to date with resident vaccination rates. They were not aware there were several residents who consented to having the pneumonia vaccine and were not vaccinated. The staff did their part to order the vaccines, but the purchase order was not authorized due to the cost of the vaccine. They stated today the facility was in the process of getting 46 vaccines and the residents would receive their vaccines that day. Residents over the age of 65 had a higher risk of getting pneumonia and if not vaccinated, pneumonia could progress with complications that could require hospitalization . It was the residents' choice to be vaccinated and they should receive it if requested. During an interview on 3/25/2024 at 2:07 PM, Administrator #1 stated they did not have the exact details of when the vaccine purchase order was denied but thought it may have started in June of 2023. The Infection Preventionist submitted another purchase request in December 2023 and was told because the cost was over $10,000 it needed to go to the legislature and that could take 2 months. They stated the Deputy Administrator of Fiscal should have told the Infection Preventionist how to order the vaccine differently to keep the cost lower. The Medical Director was not made aware of this issue until today, 3/25/2024. The residents should have been provided with the pneumonia vaccine if they wanted it. During an interview on 03/25/24 2:38 PM, licensed practical nurse/Infection Preventionist #5 stated the last successful order was 6/6/2023. They expected if an order was not approved, they would be notified. They stated they called the fiscal department 3-4 times after initial email on 1/23/24 and was told the order was declined due to cost. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview on 3/25/24 at 3:17 PM, the Deputy Administrator for Fiscal Services stated nursing submitted the vaccine purchase request on 11/7/2023 via electronic mail. The problem was the request was over the $10,000 limit. It should have been ordered, but they were supposed to follow the financial rules of the county. They sent licensed practical nurse/Infection Preventionist #5 the listing of those groups the facility could order from in November and December of 2023. The last successful order of a pneumococcal vaccine was in 2023. They thought the purchase order date was 6/13/23 for 3 boxes. During an additional interview on 3/26/2024 at 11:05 AM, the Medical Director stated they assumed the vaccinations were being provided to the residents. Nursing staff obtained the consents from the residents to administer the vaccines and they assumed the vaccines were given. The residents over age 65 were at a 10 times higher risk of developing pneumonia. During an interview on 3/27/24 at 2:25 PM, the Deputy Administrator of Fiscal stated there was a hold on purchasing through the county for fiscal year end, 12/8/2023-1/8/2024. They were trying to find a vendor that would honor their price. The Administrator should get quotes from the established vendors, and then follow up to see if anyone would honor their price. They stated that the urgency of the lack of vaccines was not conveyed to accounting. They could have put in an emergency order like they did during COVID, but it was not presented as urgent. _____ Immediate jeopardy was identified, and the facility Administrator was notified on 3/25/24 at 7:00 PM. Immediate jeopardy was removed on 3/27/2024 at 2:45 PM prior to survey exit based on the following corrective actions taken: -On 3/25/2024 on the evening shift, all 44 residents who had signed consent to receive the pneumonia vaccine were vaccinated. The facility reviewed their immunization and vaccination policies and made revisions. -On 3/26/2024, an outside consultant provided education about the federal requirements for the pneumonia vaccine. The education was attended by the Administrator, the Deputy Director of Fiscal Services, the Assistant Director of Nursing, the Deputy Administrator for Administrative Services, and the Infection Preventionist. - Confirmation was made that all 44 residents that requested and consented to have the pneumonia vaccine had been vaccinated on 3/25/2024. - The Director of Nursing, Infection Preventionist, and staff educator provided education to all licensed nurses. (continued on next page)

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F 0883 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	- The education included the policy related to pneumonia vaccination, communication with a provider and obtaining medical orders for vaccines, communication with providers on vaccines that were ordered and were not available, the pneumonia vaccine order should be entered into the electronic record and once delivered administered timely, purchasing and ordering vaccines. Additional re-education focused on new admission related to pneumonia vaccine status and the signed declination with education for the resident who declined. A posttest was initiated to ensure retention of the training information. 88.1 % of the staff were successfully educated with a plan to educated employees that were not scheduled to work or out on leave to be educated prior to resuming work duties. - Future vaccine purchasing denials due to cost related issues would be reviewed by the Administrator and referred to the fiscal officer for further review and approval. - The Administrator and the Director of Nursing planned to conduct an audit and the results would be reviewed by their quality assurance and performance improvement committee for six months. 10NYCRR 415.19(a)(1-3) 48632