

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Mercy Hospital Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Melroy Avenue Lackawanna, NY 14218	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 7/24/25, the facility did not ensure: they assessed all residents for risk of entrapment from bed rails prior to installation, they reviewed the risks and benefits of bed rails with the resident or resident representative, obtain informed consent prior to installation, or provide documentation that preventive maintenance was conducted for all bed rails for four (4) (Residents #7, 9, 27, and 50) of four (4) residents reviewed. Specifically, the U Rails were loose and not secure (Resident's #27 and #50); lacked evidence of consent and risks verses benefits; and there was no routine preventative maintenance (Resident #7, 9, 27, & 50). In addition, the U-Rails were installed in error (Resident #50) and not reflected on the care plan (Resident #7 and # 50).The findings are: The policy and procedure titled CBC: Use of U-Rails, dated 4/24/25 documented if a U-Rail is recommended, patient/resident representative will be educated on the risks and benefits of the U-Rail. Informed consent will be documented in the medical record. U-Rails will be documented as a device for aiding mobility. Maintenance/Designee will conduct entrapment zones utilizing the attached U-Rail Assessment Decision Tree. The procedure did not include who was responsible for obtaining consents or the risk benefit education. The Bed Lever (U-Rail) Instruction manual dated December 2018 documented the bed lever should be regularly checked by the carer/user to ensure the setup is correct and it is working as intended for the user. 1. Resident #50 had diagnoses including Alzheimer's, depression, and anxiety. The Minimum Data Set Assessment (a resident assessment tool), dated 5/7/25, documented Resident #50 had severe cognitive impairment, sometimes understood and sometimes understands. The Minimum Data Set documented that Resident #50 was independent for bed mobility and bed rails were not used. The Kardex Report (a guide used by staff to provide care) with the as of date of 7/22/25 did not reflect bilateral U-rails. The comprehensive care plan revised on 4/6/25 documented Resident #50 had repeated falls, poor safety awareness, and was independent with bed mobility. The comprehensive care plan did not document the use of the U Rails. The Physical Therapy Evaluation and Plan of Treatment provided by the facility on 7/22/25 and was dated 11/18/24 documented Resident #50 was independent for bed mobility. There were no recommendations for U-Rails. Review of the electronic medical record revealed there was no U-Rail Assessment Decision Tree for Resident #50. During observation on 7/17/25 at 11:57 AM, Resident #50's bed was positioned up against the wall in their bedroom. The bed had bilateral U-Rails. The right U-Rail moved two to three inches forward and backwards when pressed on and was not secure. During observation on 7/21/25 at 3:17 PM, Resident #50's right U-rail extended two to three inches from the mattress when moved back and forth. During observation and interview on 7/21/25 at 3:44 PM, Licensed Practical Nurse #3 stated Resident #50 used the U-Rail for bed mobility to maintain their independence. Licensed Practical Nurse #3 moved the U-Rail and stated it was crooked and wobbly while moving it back and forth. Licensed Practical Nurse # located the two black bolt knobs located on the inside of the bedframe and attempted to tighten the bolts but was unable to do so. Licensed Practical Nurse #3 (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evaluation dated 12/16/24 documented use of assistive U-Rails for rolling with bed mobility. Review of U-Rail Assessment Decision Tree forms dated 8/4/22 - 6/17/25 for Resident #27 revealed there was no evidence that informed consent was obtained and that education was provided on the risks and benefits of the U-Rails. During observations on 7/18/25 at 10:40 AM and 2:16 PM, 7/21/25 at 9:52 AM and 3:05 PM, Resident #27's bed had bilateral U-Rails at the head of the bed. The U-Rail on the left side, was loose, wobbled 2-3 inches, and the 2 screws securing the U-Rail to the bed frame were not secure. During an interview on 7/21/25 at 9:52 AM, Resident #27's was out of bed sitting in wheelchair in room and stated the U-Rail kind of gives because it was loose. Resident #27 did not know if anyone was aware of the U-Rail being loose. During an observation and interview on 7/21/25 at 3:07 PM, Certified Nurse Aide #8 stated they were responsible to ensure residents who had U-Rails were able to use them and to assist them with the use of the U-Rails. They stated they were not responsible for putting the U-Rails on the bed but if they were loose, wobble or anything was out of place they would notify the nursing supervisor. They stated it was important to report concerns with the U-Rails to prevent falls, potential serious injuries to the residents or someone else. Certified Nurse Aide #8 observed the U-Rail in Resident #27's room and stated the left U-Rail was very wobbly. They attempted to tighten the screws attaching the U-Rail to the bed frame and were unable to. During an observation and interview on 7/21/25 at 3:21 PM, Licensed Practical Nurse #3 stated U-Rails were utilized by residents to assist with mobility, turning and positioning while in bed. Licensed Practical Nurse #3 stated if a U-Rail were ever loose, they would notify therapy, and/or maintenance to check them. They stated if a resident relied on U-Rails for mobility and they were loose there could be risk of injury with their use. Licensed Practical Nurse #3 stated they were not aware of any loose U-Rails on Unit 3. Upon observation on Resident #27's left U-Rail in room, Licensed Practical Nurse #3 stated the U-Rail did not seem secured, very loose. Resident #27 stated Yes, it is. During an interview on 7/22/25 at 9:42 AM, Physical Therapist #1 stated residents were assessed for the use of U-Rails based on nursing, family request or an observed resident need. They stated U-Rails were utilized to enhance mobility, assist with turning and positioning and getting out of bed. They stated either nursing or they explained to residents' families that the U-Rail bed rail does not prevent falls. Physical Therapist #1 stated the use of U-Rails were reviewed quarterly to determine if use is still appropriate for residents. They stated U-Rail use was discontinued if determined they were no longer appropriate. Physical Therapist #1 stated maintenance installed the U-Rails based on therapy recommendations and that therapy did not maintain the U-Rails. They stated there was nothing documented in the resident's records regarding consent for use and/or on education regarding the risks/benefits of the use of U-Rails. They stated it would be important that education was provided because there were risks with the use of U-Rails, like entrapment, and that they were being utilized for the right reasons. During an interview on 7/24/25 at 9:35 AM, Registered Nurse #1, Clinical Nurse Manager stated they were not aware of any loose, unsecured U-Rails. They stated they would expect staff to report any U-Rail concerns to them so maintenance could be notified. They stated loose U-Rails were a risk for falls, injuries. Additionally, they stated maintenance should be checking U-Rails at least monthly to ensure everything was in working order. 3. Resident #7 had diagnoses that included spinal stenosis (narrowing of one or more areas in your spine most often in upper or lower back), history of falls, and transient cerebral ischemic attack (mini stroke). The Minimum Data Set, dated [DATE] documented Resident #7 was cognitively intact, was understood and understands. Resident #7's bed mobility was documented as supervision. The Kardex Report with an as of date 7/21/25 documented for staff to assist Resident #7 to turn/reposition every two hours, more often as needed or as requested. Bed mobility documented the use of a bed wedge on the left side for positioning per resident request. Ensure resident was lying in the middle of bed. Increase assist as needed. Requires supervision assist with rolling left to right; from a sitting to a lying position and from lying to sitting position. The Kardex Report did not document the use of U-Rails. The comprehensive care plan revised 1/11/2023 documented Resident #7 had limited (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	functional mobility related to weakness and spinal stenosis. Interventions revised on 1/31/25 documented the use of a bed wedge on the left side for positioning per the resident's request. Ensure resident was lying in the middle of bed. Increase assist as needed. On 7/22/25 interventions were revised and included use of assistive U-Rails for bed mobility. The Physical Therapy evaluation dated 11/27/24 documented the use of U-Rails with supervision for lying to sit position and rolling with bed mobility. Physical Therapy evaluation was completed on 1/27/25 at the request of nursing secondary to right sided weakness. Prior level of function for bed mobility was partial/moderate assist with U-Rails. Resident #7's safety awareness was impaired. The evaluation dated 1/27/25 did not document the use of U-Rails for bed mobility. Review of Physical Therapy progress note dated 1/31/25 Physical Therapist #1 documented they re-assessed Resident #7 and they were back to their baseline level of function. Bed Mobility recommendations were documented as supervision with U-Rails. Review of U-Rail Assessment Decision Tree form for Resident #7 dated 2/1/23 - 5/27/25 revealed there was no evidence that informed consent was obtained and that education was provided on the risks and benefits of the U-Rails. During intermittent observations on 7/18/25 at 2:11 PM, 7/21/25 at 9:07 AM and 7/22/25 at 11:13 AM Resident #7's bed had two bilateral bedrails (U-rails) to head of bed that were secure to the bed frame. During an interview and observation on 7/22/25 at 10:19 AM, Physical Therapist #1 stated Resident #7 utilizes U-Rails for bed mobility. Review of Resident #7's comprehensive care plan Physical Therapist #1 stated they had not cared planned for the use of the U-Rails for Resident #7 and should have been. Physical Therapist #1 stated there was no evidence regarding consent for use and/or on education regarding the risks/benefits of the use of the U-Rails for Resident #7. Additionally, they stated a referral was made by nursing requesting U-Rails on 2/1/23. During an interview on 7/22/25 at 10:44 AM, Assistant Administrator/Director of Environmental Services stated bed assessments were completed annually or as needed if a mattress was changed out or if U-Rails were applied to measure for risk of entrapment. They stated there was no routine, preventative maintenance that was completed related to the U-Rails. During an interview on 7/22/25 at 2:59 PM, the Director of Nursing stated they were not sure how often routine maintenance was completed on U-Rails attached to resident's beds. They stated they would expect nursing staff to report any broken items of equipment to the nursing supervisor immediately for resident safety. They stated if a U-Rail was not secured properly, was loose, the U-Rail would not be able to be utilized as indicated and could come off. The Director of Nursing stated that verbal consent was given by resident families, for the use of U-Rails but there was no documented evidence. Additionally, they stated there needed to be a more formal process, uniform way of completing U-Rail assessments to assure risks, benefits and consent for use of U-Rails was completed and documented. 4. Resident #9 had diagnoses including rheumatoid arthritis (a disorder in which the body's immune system attacks itself, primarily in the joints, causing inflammation, swelling, pain and immobility), joint contractures (joints become stiff and unable to move through their normal range of motion) and chronic pain syndrome. The Minimum Data Set, dated [DATE] documented Resident #9 was moderately cognitively impaired, was sometimes understood and sometimes understands. The resident was dependent on staff for bed mobility and bed rail use was not documented on the assessment The Kardex Report with an as of date 7/23/25 documented Resident #9 used bilateral assist U-Rails for positioning. The comprehensive care plan initiated 12/16/24 documented Resident #9 had limited functional mobility related to contractures, weakness and rheumatoid arthritis. The resident utilized U-Rails to roll to the side. The Physical Therapy Evaluation and Plan of Treatment dated 12/16/24 documented rolling left to right with substantial/max assist with U-Rails. Their prior level of functioning was max assist for bed mobility. Review of the U-Rail Decision Tree revealed Physical Therapist #1 assessed Resident #9 for U-Rail safety on 12/18/24. They were requested by a Health Care Agent for a resident who lacks capacity. Physical therapy assessment for ability to use marked with an X resident can use and exit around U-Rail, and marked with an X U-Rail is not a restraint. Resident #9 was reevaluated for safety on 12/31/24, 3/18/24 and 6/17/25. The forms did (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not include consent or risk benefit education. Review of Resident #9's medical record revealed there was no evidence that informed consent was obtained and that education was provided on the risks and benefits for the use of the U-Rails. During observations from 7/18/25 at 9:18 AM through 7/23/25 at 10:57 AM, Resident #9 was out of bed in a reclining chair in the dining room and TV lounge. Their bed was observed with U-Rails on both sides at the upper portion of the bed. During an interview on 7/23/25 at 9:38 AM, Resident #9 stated they used their U-Rails to turn themselves when staff were providing care. They did not know if they signed a consent or if their family might have and they were unsure if anyone from maintenance checked them. During an interview on 7/23/25 at 9:42 AM, Licensed Practical Nurse #5 they did not know if residents or family had to sign a consent for the use of U-Rails, and they did not think anyone did routine maintenance on the rails. Licensed Practical Nurse #5 stated it was important to maintain the U-Rails because if they became loose the resident could get hurt or even fall out of bed. During an interview on 7/23/25 at 10:45 AM, Certified Nurse Aide #10 stated they had not noticed anyone doing routine maintenance on the U-Rails. Certified Nurse Aide #10 stated it was important to maintain the U-Rails because if they became too loose the resident could get stuck between the rail and the mattress or if it was loose enough, they could lean on it and fall out of bed. During an interview on 7/23/25 at 10:57 AM, Registered Nurse #3 Clinical Nurse Manager stated there was not a routine maintenance schedule for the U-Rails but there should be. They stated it was important because the rails should never get loose enough for staff to notice and report it. The routine maintenance checks could prevent resident injuries due to U-Rails being loose. They did not obtain consents from residents or family, and they did not know if a consent was required prior to using U-Rails. 10 NYCRR 415.12(h)(1)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview, observation, and record review conducted during a Standard survey completed on 7/24/25, the facility did not ensure that residents have a right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for one (1) (#30) of three (3) residents reviewed. Specifically, there was a lack of risk versus benefit assessments and informed consents for the alarm; the alarm sounded in the room, and Resident #30 was bothered by the use of the alarm and felt undignified. The findings are: The policy and procedure titled Resident Rights dated 5/20/24 documented that each resident's rights are protected and promoted; that each resident be encouraged and assisted in the fullest exercise of these rights; and are afforded their right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration, and privacy. The policy and procedure titled Restraints dated 11/18/21 documented to provide a restraint free care while protecting resident safety, comfort and well-being; define the types of restraints, identify indications for the rare utilization of resident restraints, outline requirements of alternatives, orders obtained, and to review monitoring and documentation; and to ensure compliance with federal and state requirements for assessment and restraint reduction. The undated document titled Position Change Alarm Decision Making Tree documented the reason for the alarm request, the alternatives used before the alarm implementation, and if the alarm causes stress or anxiety which then would make the alarm a restraint. Interdisciplinary Team shall review use of a Position Change Alarm on a quarterly basis to determine need for continued use. The undated document titled Position Control Device Continued Use Determination documented the reason needed for the alarm and the use of the alarm to prevent injuries or incidents. The undated document titled Interdisciplinary Intervention for Falls Prevention documented that safety alarms such as bed or chair alarms will alarm remotely and not in the resident's room. 1. Resident #30 had diagnoses that included Parkinson's disease and dementia. The Minimum Data Set (a resident assessment tool) dated 6/17/25 documented Resident #30 was moderately cognitively intact, usually understands others, and usually understood by others. The Minimum Data Set documented the resident had a chair alarm that was used daily. The physician orders dated 1/30/25 documented Resident #30 had a chair alarm ordered and that the alarm was to be checked each shift to ensure that it is functioning. The order did not document a medical rationale. The comprehensive care plan dated 1/25/25 revealed Resident #30 was alert with confusion but could make preferences and daily choices known to staff. The comprehensive care plan documented that Resident #30 had falls on 11/2/24, 11/29/24, 12/10/24, 12/25/24, 1/4/25, 1/25/25, 1/29/25, 2/22/25, 3/18/25, 3/20/25, 4/15/25, 4/20/25, 7/11/25, and 7/22/25. The care plan included the use of the position change alarms. The Treatment Administration Records for January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, and July 2025 revealed the chair alarm (position change alarm) was to be checked for proper functioning every shift. The Position Control Device Continued Use Determination dated 12/5/24 documented the reasons Resident #30 was to have a chair alarm was for self-transfers (transferring themselves from a sitting to a standing position or from a standing position to a sitting position), ambulated on their own, and had a history of falls. A Position Control Device Continued Use Determination dated 7/1/25 documented the indication was self-transfers and ambulation on their own still occurred which required the use of the chair alarm. An observation on 7/22/25 at 12:30 PM revealed a chair alarm pad on Resident #30's recliner chair connected to an alarm box that was connected to the wall. During an interview on 7/22/25 at 12:35 PM, Resident #30 stated that they hated the alarm when it sounded in their room as it was loud, and it bothered them. They stated the alarm was used because of falls. The resident stated they didn't want the alarm because it made them feel like a terrorist. During an interview on 7/23/25 at 9:30 AM, Certified Nurse Aide #9 stated Resident #30 had complained about the chair alarm. They stated that (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #30 hated the alarm especially when it sounded in the room. They stated that the sound of the alarm bothered the resident so much the resident had thrown the alarm across the room and had attempted to pull the alarm out of the wall. They stated that they told one of the nurses about it but could not remember who they told. They stated that the alarm could be considered undignified if the resident did not like the alarm and it bothered them. During an interview on 7/23/25 at 10:15 AM, Registered Nurse Unit Manager #3 stated that chair alarms were implemented by nursing when a resident has falls. They stated the Interdisciplinary Team, which included nursing and physical therapy would decide if a resident needed an alarm. They stated that there was supposed to be a quarterly assessment completed for a chair alarm. They stated they weren't sure who would obtain consents from family or the resident for an alarm. They stated they were not aware that Resident #30 chair alarm sounded in the room. Registered Nurse Unit Manager #3 stated the alarm was supposed to alarm at the nurses' station and should activate the call light system. If the alarm sounded and it bothered the resident, it could be a quality-of-life issue. During an interview on 7/23/25 at 12:53 PM, Physical Therapist #1 stated that an assessment for use of the chair alarm should have been done quarterly and there should not have been a 7-month gap between assessments. They stated because Resident #30 had some cognitive deficits and could not be re-educated on the use of call lights that was the reason why Resident #30 had a chair alarm. They stated that nursing implements the chair alarm and that the Interdisciplinary team makes the decision to continue the chair alarm. The team does the assessment at their meetings. That's when a decision would be made to keep an alarm. During an interview on 7/24/25 at 9:30 AM, the Administrator stated assessments for alarms should be done quarterly along with the care plan for a resident. They stated the alarm should sound at the nurses' cart, the nurses' station, or sound with the call light and that it should not sound in the resident's room. They stated they would expect staff to report to the charge nurse or the nurse manager if the alarm was sounding in the resident's room and not in the nurses' station or cart. They stated that staff education was needed to ensure the alarm was not sounding in the room and to report it to someone if it was. They stated the interdisciplinary team was responsible for assessments of alarms and if a resident no longer needed an alarm, it would be removed. During an interview on 7/24/25 at 10:25 AM, the Director of Nursing stated the first time a resident complained about the noise of the alarm, they would expect staff to remove the alarm right away. They stated nursing implements the alarm, and the Interdisciplinary team was to do assessments and the risk versus benefits analysis. They stated nursing or the interdisciplinary team should obtain consents for the alarms from the responsible party or the resident. They would consider undignified if the alarm bothered the resident and it was not removed right away.10 NYCRR 415.4(a)(2)(3)		

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NAME OF PROVIDER OR SUPPLIER Mercy Hospital Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Melroy Avenue Lackawanna, NY 14218	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the Standard survey completed on 7/25/25, the facility did not provide services consistent with professional standards of care during medication administration for three (3) (#1, #20, and #77) of seven (7) residents observed. Specifically, Registered Nurse #2 administered medications that they had not personally prepared to Resident #1, #20, and #77. The findings are: The policy and procedure titled Medication Administration dated 10/24/24 documented nurses must only administer medications that they have personally prepared. Nurses must remain with the resident until the medication has been taken. The nurse will document administration of each medication in the medication administration record (MAR).1. Resident #20 had diagnoses that included chronic pain, hemiplegia (paralysis on one side of body), and polyneuropathy (peripheral nervous system disorder). The Minimum Data Set (a resident assessment tool) dated 5/14/25 documented Resident #20 was cognitively intact. During an observation on 7/21/25 at 9:11 AM, Registered Nurse #2 was applying a topical substance to Resident #20's left shoulder while they were sitting at the dining room table for breakfast. Registered Nurse #2 then obtained a medication cup from Licensed Practical Nurse #4, whom was at the medication cart, and administer a clear medication cup containing multiple medications to Resident #20. Review of the medication administration record for July 2025, Resident #20 was scheduled to receive Acyclovir 200 milligrams (antiviral), Probiotic 1 capsule (supplement), Vitamin B-Complex 1 tablet (supplement), tramadol hydrochloride (opioid), gabapentin (anticonvulsant) 100 milligrams 2 capsules, extra strength Tylenol (analgesic) 500 milligrams 2 tablets, Voltaren (pain reliever) external gel 1 percent topical to left shoulder in the morning (8 AM and 9 AM). The Medication Administration Audit Report dated 7/21/25, Licensed Practical Nurse #4 documented the administration of Resident #20's scheduled 8:00 AM and 9:00 AM medications on 7/21/25 between 9:06 AM and 9:10 AM. 2. Resident #77 had diagnoses that included dementia, macular degeneration (eye disease) right eye and anxiety disorder. The Minimum Data Set, dated [DATE] documented Resident #77 had moderate cognitive impairment. During an observation on 7/21/25 at 9:13 AM Licensed Practical Nurse #4 gave Registered Nurse #2 a clear plastic med cup of blue liquid. Registered Nurse #2 was observed delivering the med cup of blue liquid to Resident #77 and walking away. Registered Nurse #2 did not observe Resident #77 accept (swish/spit) the blue liquid. Review of the Medication Administration Record for July 2025, revealed Resident #77 had an order for Sodium Fluoride Solution 0.2 percent, one application by mouth two times a day (9:00 AM and 6:00 PM) for oral care. Instructions included to rinse for one minute then spit. Review of Medication Administration Audit Report for 7/21/25, Licensed Practical Nurse #4 documented the administration of Sodium Fluoride on 7/21/25 at 9:12 AM. 3. Resident #1 had diagnoses that included cerebral infarction (stroke), dysphagia (difficulty swallowing), and anxiety disorder. The Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. During an observation on 7/21/25 at 2:14 PM, Registered Nurse #2 was at Resident #1's room with clear plastic medication cup, containing medications and applesauce. Licensed Practical Nurse #4 was observed walking away from medication cart in another direction. Registered Nurse #2 entered Resident #1's room and closed the door with medication cup in hand. Review of medication administration record for July 2025, revealed Resident #1 had orders for buspirone hydrochloride (reduce anxiety) 5 milligrams at 2:00 PM, acetaminophen (analgesic) 500 milligrams, 2 tablets three times a day (6:00 AM, 2:00 PM, 10:00 PM), and baclofen (muscle relaxant) 10 milligrams three times a day (9:00 AM, 2:00 PM, 9:00 PM). Review of Medication Administration Audit Report for 7/21/25, Licensed Practical Nurse #4 documented the administration of buspirone, acetaminophen, and baclofen on 7/21/25 at 2:14 PM. During an interview on 7/21/25 at 2:18 PM, Registered Nurse #2 stated they should not have administered medication that were prepared by another nurse. They stated if they did not prepare the medications, they do not know what they were (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Mercy Hospital Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Melroy Avenue Lackawanna, NY 14218	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	giving. Registered Nurse #2 stated they just brought applesauce to Resident #1 and denied giving Resident #1 medications at 2:14 PM. Registered Nurse #2 stated they should not have administered Resident #20's and Resident #77's morning medications. because the medications were prepared by Licensed Practical Nurse #4. Registered Nurse #2 stated they did not sign for the administration of any medication on 7/21/25. During an interview on 7/21/25 at 2:29 PM, Licensed Practical Nurse #4 stated Registered Nurse #2 was helping them with the medication pass. They stated they were the assigned medication nurse for the unit; had not administered all the residents their medications but documented as the administrating nurse for all the medications. Licensed Practical Nurse #4 stated they prepared Resident #1's 2:00 PM medications in applesauce which included buspirone, acetaminophen, and baclofen. Registered Nurse #2 was present. Licensed Practical Nurse #4 stated they should have administered the medications because they prepared and signed for the medications. Additionally, they stated they could not verify if Registered Nurse #2 administered the medications to Residents #1, 20 and 77. During an interview on 7/22/25 at 2:59 PM, the Director of Nursing stated nurses should not be administering medications that have been prepared by another nurse because they were not following proper medication pass protocols.10 NYCRR 415.12 (l)		