STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey, it was determined that for 1 (Residents #71) of 23 residents reviewed, the facility did not develop and implement a plan of care for all residents that included measurable objectives and interventions to address all of the resident's medical and physical needs. Specifically, Resident #71's Comprehensive Care Plan and Kardex (a care plan used by the Certified Nursing Assistants to provide daily care) did not include that the resident was hard of hearing or required hearing aids. This is evidenced by the following: The facility policy, Care Plans - Comprehensive, dated October 2019, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Additionally, the comprehensive, person-centered care plan will incorporate identified problem areas and the interdisciplinary team reviews and updates the care plan when there has been a significant change in resident condition and at least quarterly with scheduled quarterly Minimum Data Set Assessments. Resident #71 had diagnosis that included Parkinson's disease, dysphagia (difficulty swallowing), and repeated falls. The Minimum Data Set Resident Assessments dated 2/1/24 and 5/2/24 documented the resident was moderately impaired cognitively, had highly impaired hearing and had hearing aids. The 2/1/24 Assessment also included that communication and hearing required care planning for the resident. In a medical progress note dated 4/5/24, Physician #1 documented that Resident #71 was hard of hearing. Review of Resident #71's current Comprehensive Care Plan and Kardex (care plan used by the Certified Nursing Assistants for daily care) did not include any objectives, timetables, or interventions related to hearing, hearing aids or communication concerns. During an observation and interview on 5/13/24 at 10:40 AM, Resident #71 stated they were could not hear well and did not have their hearing aids in. During an observation on 5/15/24 at 10:11 AM, a sign posted by Resident #71's family behind their recliner documented that the resident was hard of hearing and wore hearing aids. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 5/16/24 at 9:32 AM, and again at 4:46 PM, Resident #71 was not wearing hearing aids which were observed in a charger behind their TV. During an interview on 5/16/24 at 9:51 AM, Certified Nursing Assistant #1 stated they use the Kardex to know how to take care of each resident and residents with hearing aids should have that listed in their Kardex. Certified Nursing Assistant #1 said Resident #71 likes to wear their hearing aids and that it is important to them to have them in. Certified Nursing Assistant #1 stated they had not put them in for the past week as they were missing. During an interview on 5/16/24 at 3:36 PM, the Licensed Practical Nurse Manager #1 stated that the care plans are completed and updated by the Registered Nurses and that Resident #71 should have a care plan for hearing and hearing aids. Licensed Practical Nurse Manager #1 stated that they should be added to the Certified Nursing Assistants care plan in the electronic medical record so they can document putting them in and taking them out. Licensed Practical Nurse Manager #1 stated Resident #71 had lost their hearing aids last week but that they were found the same day. During an interview on 05/17/24 at 11:10 AM, the Director of Nursing stated a resident who is hard of hearing and had hearing aids should have that care planned for. They stated that care plans should be person-centered and tell you everything you need in order to care for that resident. The Director of Nursing said that if it was not on the care plan, new or unfamiliar staff may not know the resident was hard of hearing or needed hearing aids. 10 NYCRR 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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** 46526 49368 Based on observations, interviews, and record reviews conducted during a Recertification Survey and complaint investigation (NY00314816) the facility did not provide services, as outlined by the resident's person-centered Comprehensive Care Plan, that met professional standards of quality for 2 (Residents #38 and #54) of 28 residents reviewed. Specifically, nursing staff did not ensure medications were consumed by the residents when administered but instead were left unattended with the residents or at the bedside. This is evidenced by the following: The facility policy, Medication Administration, dated December 2019, documented that medications shall be administered in a safe and timely manner, and as prescribed. Additionally, residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 1. Resident #38 had diagnoses including dementia, high blood pressure, and gastroesophageal reflux disease (stomach acid repeatedly flowing back into the esophagus). The Minimum Data Set Resident Assessment, dated 2/7/24, documented the resident was severely impaired cognitively, received antidepressant medication, and had no behaviors identified for that time period. Review of Resident #38's Comprehensive Care Plan initiated on 8/7/23 and revised on 5/14/24, revealed that the resident would pocket medications at times and for staff to allow extra time to take pills and swallow them. The Comprehensive Care Plan did not include residents' ability to safely self-administer medications. Resident #38's current Physician's orders included acetaminophen, Aricept (medication for dementia), Citrucel (supplement), duloxetine hydrochloride (antidepressant), omeprazole (for gastric reflux), and verapamil hydrochloride (high blood pressure). The orders did not include the resident was assessed for safe self-administration of medications. Review of Resident #38's May 2024 Medication Administration Record revealed that the above medications were signed off as administered 5/13/24 and 5/14/24. During an observation on 5/14/24 at 11:40 AM Resident #38 had eight pills in medication cup in their bedroom that were identified as acetaminophen, Aricept, Citrucel, duloxetine hydrochloride, omeprazole, verapamil hydrochloride, and bisacodyl (laxative and not an ordered medication for Resident #38). During an interview on 5/15/24 at 4:16 PM Registered Nurse #1 stated they administered Resident #38's morning medications on 5/13/24 and observed the resident put the medications in their mouth, provided a drink and assumed they swallowed the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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	During an interview on 5/16/24 at 8:41 AM Licensed Practical Nurse # 2 stated they administered Resident #38's morning medications on 5/14/24 watched the resident swallow the pills and then walked the resident down to the dining room. During an interview on 5/16/24 at 3:36 PM Licensed Practical Nurse Unit Manager (#1) stated residents should be observed when taking medications and that medications should not be left at the bedside unless there was a Physician's order. 2. Resident #54 was admitted to the facility with diagnoses including diabetes, heart failure and high blood pressure. The Minimum Data Set Resident assessment dated [DATE] documented Resident #54 was cognitively intact. During an observation on 5/16/24 at 11:40 AM, Resident #54 was sitting in their room. A medicine cup with a large white pill was observed on their bedside tray table. Resident #54 said it was a pill to settle their stomach and that the nurse (Registered Nurse #2) had brought it to them around 11:15 AM. Resident #54 said the nurses do not always watch them take their medications but thought the nurse left the medication so they did not have to come back when meals arrived. Review of current physician orders revealed simethicone (Gas-X) before meals for indigestion. Review of Resident #54's May 2024 Medication Administration Record revealed the simethicone was scheduled to be administered 11:30 AM and was documented as administered on 5/16/24 by Registered Nurse #1. During an interview on 5/16/24 at 11:49 AM, Registered Nurse #1 stated they watch residents take their medications and then usually take the medication cup once the resident has taken the medication(s). Registered Nurse #1 said they gave Resident #54 Gas-X between 11:15-11:30 AM on 5/16/24. Registered Nurse #1 said Resident #54 will usually take the Gas-X when their meal tray comes but will sometimes throw it out. At 11:57 AM, the Gas-X remained on Resident #54's bedside tray table. During an interview on 5/17/24 at 10:48 AM, Licensed Practical Nurse Unit Manager #1 stated nurses should watch the residents take the pills. Licensed Practical Nurse Unit Manager #1 said medications can be left with a resident if the resident had an order to do so. During an interview on 5/17/24 at 1:55 PM Director of Nursing stated nurses should watch residents while taking their medications to ensure the medications were taken and should not be left at the bedside unless the resident had an order for self-administering medications. 10 NYCRR 415.11(c)(3)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record reviews conducted during a Recertification Survey, for one (Resident #54) of six residents reviewed the facility did not ensure that a resident who is unable to carry out Activities of Daily Living received the necessary services to maintain good grooming and personal and oral hygiene. Specifically, Resident #54 was observed to have unwashed hair and the facility could not provide evidence that the resident had received a shower in several weeks. This is evidenced by the following: The facility policy Activities of Daily Living [ADL] Care and Support, dated 3/13/24, revealed that activities of daily living care and support would be provided for residents who were unable to carry out the activities of daily living independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized care plan, that included but was not limited to supervision and assistance with: Hygiene (bathing, dressing, grooming, and oral care) and mobility (transfer and walking). The resident's bath or shower would be scheduled as per the resident preference and assessed needs-at a minimum of weekly, as needed and may include a bed bath on non-shower days. Hair care would be provided to the resident as per resident's preference and/or assessed needs or by appointment at hairdressers or barber. Resident #54 had diagnoses that included diabetes, heart failure and hypertension. The Minimum Data Set Resident assessment dated [DATE] noted Resident #54 was cognitively intact and required staff assistance with showering or bathing. The Minimum Data Set Resident assessment dated [DATE] included it was very important to Resident #54 to choose between a tub bath, shower, bed bath and sponge bath. Review of the current Comprehensive Care Plan revealed Resident #54 required assistance with showers or bathing. Additionally, Resident #54's Kardex (care plan used by the Certified Nursing Assistants for daily care) revealed the resident had a shower/bath scheduled on Tuesday and Friday evenings. During an observation and interview on 5/14/24 at 9:47 AM, Resident #54's hair appeared wet. Resident #54 stated their hair was not wet but greasy and while their hair had been washed about a week ago by the hairdresser, they had not had not had a shower in several weeks. Resident #54 said they were supposed to receive a shower on Tuesday and Friday evenings and that staff would sometimes tell them there was not enough staff to assist with a shower. Resident #54 said they managed to keep clean by washing certain areas of their body with a washcloth. When observed on 5/15/24 at 12:21 PM, the posted Unit shower schedule documented that Resident #54's showers were scheduled on Tuesday and Friday evenings. During an observation and interview on 5/15/24 at 12:57 PM, Resident #54 continued to have unwashed hair and stated they had still not received a shower the previous day (despite the schedule). Review of shower/bath documentation in the electronic health record from 4/17/24 to 5/17/24 revealed Resident #54's last shower or bath was on 4/30/24. Additionally, several dates between 5/3/24 to 5/14/24 were documented as not applicable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes from 5/1/24 to 5/17/24 did not include documentation that Resident #54 received or refused a shower or bath. During an interview on 5/16/24 at 5:20 PM, Certified Nursing Assistant #3 said their role included helping residents with activities of daily living like showering, transferring, eating, and answering call lights. Certified Nursing Assistant #3 said they were not assigned to specific residents during their shift and used the shower schedule to determine when a resident was scheduled for a shower. Certified Nursing Assistant #3 said they worked the evening shift on 5/14/24 and did not think Resident #54 received a shower with only two Certified Nursing Assistants working on the unit. During an interview on 5/17/24 at 10:48 AM, Licensed Practical Nurse Manager #1 said all residents were scheduled for two showers a week and provided based on the schedule. Licensed Practical Nurse Manager #1 said if a shower or bath was not done on the scheduled day, staff should assist the resident on another day. Licensed Practical Nurse Manager #1 said the Certified Nursing Assistants documented in the electronic health record if a bath or shower was provided and if refused, the Certified Nursing Assistants should notify the nurse. Licensed Practical Nurse Manager #1 said if the nursing staff are unable to assist a resident with a shower, it was usually because there are only two aides working on the unit. Licensed Practical Nurse Manager #1 reviewed the electronic health record at that time and said Resident #54's last documented shower was on 4/30/24. 10 NYCRR 415.12(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Recertification Survey, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, their comprehensive person-centered care plan, and the residents' choices for one (Resident #24) of one resident reviewed for pain management. Specifically, the facility did not ensure the resident's bowel status was efficiently monitored, treatment initiated timely or that the medical team was notified of complications when applicable. This is evidenced by the following: The facility policy, Bowel Management, dated revised November 2021, included that the nursing assistants document the resident's bowel movements every shift in the electronic medical record, including number, size, and consistency. The nurses review the documentation at the beginning of each shift and the nursing assistant reports to the licensed nurse or unit manager any resident who had a small or no bowel movement in nine or more shifts. If no bowel movement in three days (72 hours), the licensed nurse should initiate the bowel regimen, and document in the Medication Administration Record as follows: a. Milk of Magnesium (laxative), start on the evening shift and if ineffective by the next day proceed to Bisacodyl (laxative) suppository. b. Bisacodyl suppository, give on day shift and if ineffective by the end of evening shift, proceed to Fleet enema. c. Administer Fleet enema if there is no bowel movement. The policy included to consider additional interventions such as review of medications such as iron supplements and narcotics. Resident #24 had diagnoses including osteoporosis (condition resulting in fragile, brittle bones), vertebral compression fractures and fibromyalgia (disorder resulting in chronic widespread pain). The Minimum Data Set Resident assessment dated [DATE] documented that Resident #24 was cognitively intact and was receiving opioids (prescribed pain medications with a side effect of constipation). Review of Resident #24's Physician orders revealed senna (stool softener) twice daily for constipation and oxycodone (an opioid) every six hours as needed for pain. During an observation and interviews on 5/15/24 at 12:10 PM, Resident #24 stated they were having a hard time moving their bowels and currently felt backed up (constipated). Resident #24 said they could not recall when their last bowel movement was and requested toileting assistance at the time. When responding to assist Resident #24, Certified Nursing Assistant #9 said that the previous week, the resident had been very constipated, and that the medical provider had to give the resident an enema. Review of Bowel Movement Report in the electronic medical record revealed that from 5/1/24 to 5/7/24 at 1:45 PM, Resident #24 had no bowel movements documented or documented as 'none' until a small bowel movement documented on 5/7/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Progress Notes dated 5/1/24 to 5/6/24 revealed no documented evidence that a medical provider was notified that Resident #24 had not had a bowel movement for approximately six days. In a Readmission Follow-Up Progress Note dated 5/6/24, Physician Assistant #1 documented that Resident #24 was complaining of back pain and constipation. Physician Assistant #1 documented that Miralax would be ordered, and the resident would be closely monitored. Review of the May 2024 Medication Administration Record 5/1/24-5/6/24 revealed senna (stool softener) administered twice daily and no further laxatives until 5/7/24. During an interview on 5/16/24 at 3:13 PM, Physician Assistant #1 said the electronic medical record should provide a clinical alert (for the nurses) if the resident does not have a bowel movement for three days and if so, nursing should notify the medical provider. Physician Assistant #1 stated during the morning leadership meeting, they review residents who have not had a bowel movement in three days, and then follow the policy by administering a dose of Milk of Magnesium or bisacodyl via one-time orders, follow-up the next day and if the resident did not have a bowel movement an enema would be administered. Physician Assistant #1 said that Resident #24 had returned from the hospital on 5/1/24 following a gastrointestinal bleed. Physician Assistant #1 said they were first notified Resident #24 had not had a bowel movement on 5/6/24 and ordered Miralax and an increased dose of senna. Physician Assistant #1 said Resident #24 started passing stool on 5/7/24, which was being counted by the nursing staff (as a small bowel movement), but it was not substantial enough and on 5/8/24 Resident #24 required a disimpaction (removal of stool manually). Physician Assistant #1 stated that after speaking to the Certified Nursing Assistants it came to their attention that the experienced aides (Certified Nursing Assistants) knew that a small pebble or two (of stool) should not be counted as a bowel movement but not the less experienced aides. During an interview on 5/16/24 at 5:20 PM, Certified Nursing Assistant #3 said when documenting bowel movements, they document the size, consistency and if the resident was continent or incontinent and used their best judgment as to size. During an interview on 5/17/24 at 12:13 PM, Licensed Practical Nurse Manager #2 said if a resident has not had a bowel movement on day three, they give docusate (stool softener) and then on day four a suppository and on day five an enema. Licensed Practical Nurse Manager #2 said the medical provider should be notified on day five if no bowel movement. Licensed Practical Nurse Manager #2 said they ran the No Bowel Movement report for Resident #24 on 5/6/24 because they were not in the facility on 5/4/24 or 5/5/24 (weekends) and that the nurses should check (in the electronic medical record) to see when residents' last bowel movement was. Licensed Practical Nurse Manager #2 said Resident #24 was admitted back to their unit from the hospital on 5/1/24, and the hospital reported that the resident had a bowel movement on 5/1/24. Licensed Practical Nurse Manager #2 said a medical provider should have been notified sooner that Resident #24 had not had a bowel movement. During an interview on 5/17/2 at 1:55 PM, the Director of Nursing said nurses (mainly the nurse managers, but some medication nurses) should run the bowel reports from the electronic medical record at the start of every shift for residents who flagged as having no bowel movements for three days. The Director of Nursing said if a resident was on the list and was confirmed to not have had a bowel movement in three days, the bowel regimen should be started. The Director of Nursing said the bowel regimen medications are not standing orders and nursing should contact the medical provider on the third day for orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47641 Based on interviews and record reviews conducted during the Recertification Survey and complaint investigations (NY00314816, NY00316629, NY00302113), it was determined that the facility did not ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents in the facility. Specifically, there was not sufficient staff to meet all resident needs with activities of daily living, including timely showers, long waits for addressing call lights and assistance with activities of daily living (eating, toileting, personal hygiene.). This is evidenced by but not limited to the following: For additional information see Centers for Medicare/Medicaid Services Form 2567: F677 - Activities of Daily Living Care for Dependent Residents (Resident #54). F732 - Posted Nurse Staffing Information. The Facility Assessment provided by the facility, dated 2/29/24, did not include facility minimum staffing numbers, but did include 'staffing plan-see attached.' There was no facility staffing plan attached or provided. During the entrance conference on 5/13/24 the Administrator stated the current facility census was 102 residents. Review of the licensed nursing staff (Registered Nurses and Licensed Practical Nurses) and Certified Nursing Assistants on-duty schedules provided by the facility for the months of April & May 2024 revealed but not limited to the following: a. The facility nursing schedules for all three shifts documented the resident census of 103 daily for the entire two-month time frame. b. On 4/21/24 day shift there 2 licensed nurses from 11:00 AM to 3:00 PM for morning medications and treatments for 103 or 51.5 residents per licensed nurse and no nursing supervisor scheduled. c. On 4/21/24 evening shift there were 4 Certified Nursing Assistants from 3:00 PM to 7:00 PM and 3 Certified Nursing Assistants from 7:00 PM to 11:00 PM (to assist residents with bedtime care, including incontinence care, toileting, meals and answering call bells.), and 3 licensed nurses for 103 residents. No nursing supervisor was documented as working this shift. d. On 4/26/24 night shift there were two Certified Nursing Assistants from 11:00 PM to 3:00 AM for a census of 103 (51.5 residents per Certified Nursing Assistant). e. On 4/28/24 day shift there were 3 licensed nurses documented as working for 103 residents or 34 residents per licensed nurse. There was no nursing supervisor documented as working this shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 5/1/24 night shift there were 2 licensed nurses from 3:00 AM to 7:00 AM and 2 Certified Nursing Assistants from 5:00 AM to 7:00 AM for 103 residents or 51.5 residents per staff. There was no nursing supervisor documented as working this shift. g. On 5/11/24 day shift there were 3 licensed nurses 7:00 AM to 11:00 AM for 103 residents. There was no nursing supervisor documented as working this shift. h. On 5/14/24 evening shift there were a total of 6 Certified Nursing Assistants for 103 residents or 17 residents per Certified Nursing Assistant for afternoon and evening care, including meals, bathing, incontinence care, toileting, and answering call bells. Review of Resident Council meeting notes dated 4/26/24, revealed that residents raised concerns regarding long call light wait times. The meeting minutes provided by the facility did not address a plan for resolution. During multiple resident interviews conducted 5/13/24 and 5/14/24, 8 of 19 residents interviewed complained of not enough staff to assist them with activities of daily living (meals, showers, personal hygiene, toileting) especially on the evening and night shifts and on weekends. In an observation on 5/13/24 at 11:03 AM Resident #86 was in the hallway in a wheelchair with uncombed hair and a disheveled appearance. In an observation on 5/13/24 at 11:04 AM Resident #70 had uncut nails and several dirty nails filled with brown debris. Resident #70 stated at the time that the aides cannot cut their nails and it had been 6 months since a nurse cut them. In an observation on 5/13/24 at 11:29 AM Resident #30 was ungroomed with numerous chin hairs and fingernails filled with brown debris. On 5/14/24 at 10:13 AM the resident's nails remained dirty. In an observation on 5/14/24 at 9:10 AM Resident #14 had long jagged nails and stated that the aides and nurses do not have enough time to cut their nails and sometimes they do not get their showers. During a Resident Council meeting held on 5/15/24 at 9:00 AM with eight residents participating; residents stated there were long call light wait times of up to one hour for help and that staffing was so poor they were cutting corners for care (showers, hygiene, toileting). Residents stated that there was usually two aides and one nurse on the night shift and sometimes only two staff on the evening shift and it took so long to serve meals, the food was cold. Residents said that due to staffing they were expected to all be in bed by 7:00 PM. During an interview on 5/13/24 at 11:00 AM Resident #70 stated they are short of Certified Nursing Assistants, so it takes a while, sometimes for over an hour to answer call lights. During an interview on 5/13/24 at 11:48 AM, a family member stated sometimes it is very difficult to find staff to provide assistance (toileting). The family member stated that on the day prior they walked around the entire unit for about 15 minutes and could not find any staff to assist the resident who was unable to wait to use the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/13/24 at 3:36 PM Resident #37 stated staffing on evenings and weekends is the worst as sometimes there are only two Certified Nursing Assistants for the unit (a 40-bed unit) which happened (the previous) Saturday and then they had to wait for over an hour for any assistance. During an interview on 5/14/24 at 8:53 AM Resident #69 stated they are short staffed all the time, sometimes only two Certified Nursing Assistants for the unit (40 beds). Resident #69 said that several residents need two staff to assist with transferring and often have to do it with just one or on their own. We just get told they (administration) are working on it. In an interview on 5/14/24 at 9:03 AM Resident #14 stated staffing is not very good on the evenings, overnights and weekends and sometimes there is only one Certified Nursing Assistant for the whole floor (40-bed unit) at night. During an observation and interview on 5/14/24 at 9:47 AM Resident #54 was observed with greasy (wet appearing) hair. Resident #54 stated that their hair was not wet, but was greasy, that their hair was washed the week prior by the hairdresser but that they had not had a shower in weeks. Resident #54 said they are supposed to receive a shower on Tuesday and Friday evenings (twice a week) but staff tell them that they do not have enough staff to assist them with showers. In an interview on 5/14/24 at 9:54 AM Resident #50 said the facility did not have enough help (staff) and must wait up to an hour for help because they need the stand lift to go to the bathroom. Resident #50 said that sometimes they have to wait for half an hour (sitting in the dining room) before they get their meal. During an interview on 5/15/24 at 4:51 PM Certified Nursing Assistant #7 stated there are only two of us most (evening) shifts (40-bed unit). Certified Nursing Assist #7 stated often we cannot complete showers because we do not have enough time and sometimes, we are only able to get one set of rounds (checking for incontinence or other needs) for the shift. In an interview on 5/15/24 at 5:05 PM Certified Nursing Assistant #8 stated there were two Certified Nursing Assistants working that evening shift (40-bed unit), and that there were some days when they are the only Certified Nursing Assistant for the whole unit. Certified Nursing Assistant #8 stated they often can do only one, maybe two rounds the entire shift and are not able to provide showers or turn (reposition) residents. During an interview on 5/16/24 at 9:44 AM Certified Nursing Assistant #4 stated if there was a call-in (staff who call in unable to work) for the next shift and supervisors are unable to fill it, they work short causing them to provide care alone to residents requiring two assists. Certified Nursing Assistant #4 stated some tasks that they cannot complete due to staffing are nail care and showers. In an interview on 5/16/24 at 9:56 AM Certified Nursing Assistant #2 stated weekends are short-staffed, sometimes two Certified Nursing Assistants for the evening shift. Certified Nursing Assistant #2 stated the facility expects us to have everyone in bed by 7:00 PM before we leave (12-hour shift 7:00 AM- 7:00 PM). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/24 at 10:05 AM Certified Nursing Assistant #5 stated they change all the residents by themselves and were unaware of any residents who required two staff assist because on the night shift they often work by themselves with no other staff to ask for help as the other units also have one Certified Nursing Assistant. Certified Nursing Assistant #5 stated showers and baths are difficult to complete as there are typically only two Certified Nursing Assistants on the day shift. If a third one is scheduled, they usually are sent on a (resident) transport or floated to another unit. During an interview on 5/16/24 at 4:38 PM the Human Resources Director (identified as responsible for the staffing schedule) stated on a typical day shift they like to have about 15-16 total Certified Nursing Assistants, on the evening shift 9, which is harder to get, and on night shift they attempt 6 or 2 per unit but unfortunately it goes in waves. The Human Resources Director stated that they have had some complaints from family & staff, but they go to the Social Worker to address. When reviewed the provided schedules did not include call-ins. The Human Resources Director stated there should be a code for call-offs (call-ins) and they did not know why they were not on the schedules provided. The Human Resources Director stated the staffing schedules provided should be accurate as they edit them in payroll. In an interview on 5/16/24 at 5:20 PM Certified Nursing Assistant #3 stated they worked on 5/14/24 evening shift and that Resident #54 did not receive their shower because they only had two Certified Nursing Assistants (40-bed unit). In an interview on 5/16/24 at 5:40 PM Certified Nursing Assistant #6 stated that there are only two Certified Nursing Assistants on the evening shift, and they have a hard time completing showers, doing hoyer transfers, change residents, feed residents or do any nail care. During an interview on 5/16/24 at 6:23 PM Licensed Practical Nurse #3 stated that they have had to stay longer than their scheduled 8 hours to get their treatments completed and that while they do get treatments done, they are not timely. In an interview on 5/17/24 at 9:36 AM Licensed Practical Nurse Manager #2 stated there were 40 residents on the unit and they had one nurse and 3 Certified Nursing Assistants as a fourth aide went out on transport. Evening shifts are usually one nurse two aides due to call-offs as was the case last evening. Licensed Practical Nurse Manager #2 stated they were unaware of any tasks that were not able to be completed due to staffing and were unaware that residents were not receiving showers when they were scheduled to do so. In an interview on 5/17/24 at 10:46 AM The Director of Nursing stated they should have two nurses on every unit on the day shift and one to two on the evening shift (depending on the unit) but there are struggles for these numbers. For the night shift we should have one Licensed Practical Nurse on every unit and a Registered Nurse present as well. The Director of Nursing stated that they should have three or four Certified Nursing Assistants on each unit day shift and at least three on each unit on evening shift but with call-ins it can get tough. Night shift should have two Certified Nursing Assistants on every unit but often only one due to call-ins. The Director of Nursing stated they were not aware that showers were not being done or that staff were completing care alone for residents requiring two staff assist due to staffing. 10 NYCRR 415.13 (a)(1)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 47641 Based on observations, interviews, and record reviews conducted during a Recertification Survey, the facility did not ensure the nurse staffing information was posted daily and included the required information. Specifically, the nurse staffing information did not consistently include the accurate number and total hours worked by licensed and unlicensed nursing staff who were directly responsible for resident care, the accurate daily resident census (the number of residents currently residing in the facility) and did not include any changes in nurse staffing throughout the day per the regulations. The facility was also unable to provide the accurate posted staffing sheets for the prior 18 months as required by law. This is evidenced by the following: During observations on 5/13/24 at 11:01 AM, 5/15/24 at 11:00 AM and again at 4:40 PM, and 5/17/24 at 12:47 PM the facility's posted nurse staffing information documented the current resident census at 103 each day (despite the Administrator informing the survey team that the resident census on 5/13/24 was 102). The posted information did not include the accurate hours worked for licensed and unlicensed nursing staff when compared to the provided nursing schedules. Review of the daily staffing information from 4/1/24 to 5/17/24 revealed multiple days that did not include resident census or the accurate number and hours worked by each discipline when reviewed with the staffing schedules. During an interview on 5/16/24 at 4:38 PM, the Human Resources Director (who is in charge of staffing) stated the Administrator prints the daily staffing sheets from the computer and posts them. The Human Resources director stated the resident census of 103 was an average, and that they were only responsible for changing the number of staff and that the Administrator was be responsible for updating the resident census as they did not know how to change it in the computer system. When asked to review an example of the posted staffing sheets (from the computer system) for April 25th which revealed from 11:00 PM to 7:00 AM there were two Certified Nursing Assistants for a total of eight hours for the whole shift, the Human Resources Director said it did not make sense if each Certified Nursing Assistant worked 7.5 hours each. Review of the nursing schedule for April 25th revealed three Certified Nursing Assistants scheduled for the same shift. The Human Resources Director stated that if there were any changes in staffing, they would be changed on the actual paper sheets that were posted but not in the computer system. The Human Resources Director stated they shredded the staff sheets that were actually posted until that morning when they were instructed to save them. In an interview on 5/17/24 at 11:23 AM The Administrator stated the facility has been using the computer system for their posted nurse staffing for approximately a year and a half, prior to that they were handwritten and were saved. The Administrator stated that they change the posted staffing quite often (due to changes in staff) but that the ones that identified the changes had been tossed. 10 NYCRR 415.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49447 Based on observations, interviews, and record reviews conducted during the Recertification Survey, the facility did not ensure that all drugs and biologicals in the facility were properly stored in accordance with State and Federal Laws for two (Keuka and Lamoka Units) of three medication carts and two (Keuka and Lamoka Units) of two medication storage rooms reviewed. Specifically, medication carts contained expired medications, unidentified loose pills and/or insulin pens undated as to when they were opened or when they expired. Medication storage rooms contained multiple bottles of expired medications. This is evidenced by the following: The facility policy Medication-Storage, dated January 2019, revealed that expired, discontinued, and/or contaminated medications should be removed from medication storage areas and disposed of in accordance with facility policy. During an observation on 5/14/24 at 11:15 AM, the Keuka Unit medication cart contained multiple expired medications that included bottles of allergy medication, aspirin, and vitamins with expiration dates as old as 12/22/23. Additionally, the cart contained opened insulin pens that were not dated as to when opened or when expired. During an interview on 5/14/24 at 11:21 AM, Licensed Practical Nurse #4 stated when retrieving a stock medication, they made sure it was the right medication and would check the expiration date before administering it. Licensed Practical Nurse #4 stated they were not aware of any medication cart audits, but each nurse was responsible for monitoring their own cart for expired medications and if found the Nurse Manager should be informed. During an interview on 5/14/24 at 11:35 AM, Licensed Practical Nurse Manager #1 stated that expired medications and bottles without expiration dates should have been discarded. When insulin was opened it should be marked with the open and expiration dates. Licensed Practical Nurse Manager #1 stated that medication carts should be cleaned regularly and contain no loose pills, expired or unlabeled medications. During an observation on 5/14/24 at 11:51 AM, the Keuka Unit medication room also contained multiple bottles of expired vitamins and antacid medications (expired August 2023). During an observation and interview on 5/14/24 at 12:15 PM the Lamoka Unit medication cart contained multiple unidentified loose pills. When interviewed at this time Licensed Practical Nurse #1 stated that each nurse should be checking for expired medications and was not sure who monitored the medication rooms for expired medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/14/23 at 12:23 PM, the Lamoka Unit medication room contained multiple expired medications including but not limited to multiple bottles of vitamins, minerals, stool softeners, laxatives, antacids, and nasal sprays with expiration dates as old as September 2023. When interviewed at that time, Registered Nurse Manager #1 stated the expired medications should not have been in the medication room and that they were unsure of what the facility did to track or audit medications. During an interview on 5/16/24 at 10:14 AM, the Director of Nursing stated there should not be any expired medications stored in the medication carts or medication rooms. The floor nurses and the unit managers should be checking for expired medications in the medication rooms and carts. The Director of Nursing stated that insulin pens should be labeled with resident identifiers and the date the insulin pen was opened. The Director of Nursing stated the expired medications may have been found in the carts and rooms due to not having been checked in a while. In the past, medication cart and room audits had been completed by the Assistant Director of Nursing. During an interview on 5/16/24 at 10:32 AM, the Assistant Director of Nursing stated audits were done on medication rooms and carts monthly. The Assistant Director of Nursing stated they last completed an audit of the medication carts and rooms approximately one month ago and may not have looked well enough and missed the expired medications. 10 NYCRR 415.18(d)(e)(1-4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49368 Based on observations, interview, and record review conducted during the Recertification Survey, it was determined that for the three (Keuka, Lamoka, and [NAME]) of three resident units the facility did not properly maintain the resident call system. Specifically, elements of the nurse call system were not functioning properly, and modifications made to parts of the call system did not relay the call directly to a staff member or centralized workstation. The findings are: Record review of a document titled: 'Resident Council: Meeting Minutes' dated 4/26/24 included one resident complaint that the call light/pull cord in their bathroom was broken (room [ROOM NUMBER]B). The document included that they were given a tap bell, but the resident did not feel it was adequate should something happen. Observations on 5/13/24 at 1:10 PM included an orange lanyard holding a black device with a red 'Call' button and a blue number '3' at the top and was located on the bed of room [ROOM NUMBER]A ([NAME] Unit). Observations on 5/14/24 at 10:34 AM included an orange lanyard holding a black device with a red 'Call' button and a blue number '6' at the top and was located on the bed of room [ROOM NUMBER]B ([NAME] Unit). Similar devices were also observed in resident room [ROOM NUMBER]B with a number '1' on the device on the bed, and number '2' on the device in the bathroom. Record review of a proposal provided by the facility, for a 'Jeron' brand resident call system dated March 6, 2007 included a description sheet showing a touchscreen master, nurse master console, satellite master console, and a direct select master console as part of a resident call system to be installed along with description sheets for other parts of the call system. In an interview on 5/14/24 at 10:35 AM Certified Nursing Assistant #2 stated the 'fob' system, 'Call to U' brand wireless caregiver pager (as described above), has a sound that only rings twice because the sound does not work for the 'Jeron' push button call lights in resident rooms 212, 213, 214, and 215 for the beds and bathrooms. Certified Nursing Assistant #2 stated that in those rooms some of the lights turn on and do not make a sound and the 'Call to U' brand system was put in those rooms last week where there were no lights or sounds. Certified Nursing Assistant #2 also stated that staff cannot determine who is pressing the call bell since it only sounds twice and the plug-in units (receiver for the wireless 'Call to U' system) only stay lit up for a few seconds. Certified Nursing Assistant #2 stated that there is not always staff around to hear the sound and that they have asked the Director of Maintenance to fix the original call light system but were told the issue was in the wiring and this was what they came up with as a temporary fix. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/14/24 at 11:55 the Director of Maintenance stated that there is a problem with the nurse call system in three resident rooms on the 2nd floor ([NAME]), and the call lights for one room had the A bed working but the B bed was not. The Director of Maintenance stated that there is an electrician coming out next week to figure out what's going on with those rooms, and in between they ordered this system (Call to U brand) that works wirelessly and installed it on 5/10/24. The Director of Maintenance stated that they plugged in three remote boxes (receivers) so that all three corridors of that unit ([NAME]) can hear the tone when the system is activated. The boxes (receivers) were observed to have numbers from one to six that light up when activated. Observations on 5/14/24 at 12:05 PM included an extra 'Call to U' unit in the Director of Maintenance's office was plugged in and activated to demonstrate. When the call device was pressed, the receiver box rang like a doorbell once, and one of the numbers lit up, but went out after approximately five-seconds. The Director of Maintenance stated that unless staff were in front of the box, they have to check all three rooms to see who requested assistance, and staff do not have the receiver devices in their possession. When the surveyor questioned about the light turning off, the Director of Maintenance replied, that's a fault of the system. The Director of Maintenance stated that the Jeron nurse call system is monitored by their vendor and all repairs are done by them. On 5/15/24 at 12:18 PM, a monitor (screen) was observed on the counter of the first floor Keuka Unit nurse station. The monitor was labeled as 'Jeron, Provider Nurse Call System' and the monitor screen was black and appeared to not be functional. In an interview on 5/15/24 at 1:34 PM the Director of Maintenance stated that they have lights and sound in the hallway with the Jeron nurse call system, but they don't have a monitor on the Keuka Unit that lights up and has audio. The Director of Maintenance also stated that the second floor [NAME] Unit has a monitor, but it does not work because the box under the desk needs to be replaced. The Director of Maintenance stated that they all have tones but cannot see what room it is coming from. The Director of Maintenance stated and that the vendor is not coming in for the monitors but are coming in for the three rooms with a problem. The Director of Maintenance stated the three rooms with the call light problem had been going on prior to when they came to the facility in June of 2022. The Director of Maintenance also stated that they were told that the call system was obsolete, and they have a proposal in process to get a new call system for the second floor Lamoka Unit, and they plan to use the parts removed to fix the rest of the nurse call system problems. Observations on 5/16/24 at 11:25 AM included a red light was blinking and sounding on the ceiling in the corridor between the Keuka Unit nurse station and activities room. The central nurse call monitoring screen at the nurse station was observed to be black (not functional). During an interview on 5/17/24 at 10:48 AM, Licensed Practical Nurse Manager #1 stated that the call bell lights illuminate outside the resident's room (if the call bell button is pressed). The Licensed Practical Nurse Manager #1 said the red blinking lights are bathroom call lights and lights will also illuminate in the back of the unit for the staff in the hallways to see (white or red depending on resident's room or bathroom). Licensed Practical Nurse Manager #1 said the monitor at the nurses' station does not work but that they do not need it to work because staff do not sit at the nurses' station. 10NYCRR: 415.29, 415.29(b); 415.29(j)(1) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10NYCRR: 713-3.25(g)