

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49368</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, the facility did not allow a resident the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident for one (Resident #31) of five residents reviewed for accidents. Specifically, Resident #31's side rails that were used to increase their independence and mobility in bed were removed by the facility as considered being a restraint without an appropriate assessment resulting in a fall out of bed with injury. This resulted in actual harm to Resident #31 that was not Immediate Jeopardy and is evidenced by the following:</p> <p>The facility policy Use of Side Rails, last reviewed January 2024, documented side rails are considered a restraint when they are used to limit the resident's freedom of movement. Side rails are permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. An assessment will be made to determine the resident's medical symptoms or to assist with mobility and transfers of residents.</p> <p>Resident #31 had diagnoses including a stroke with left hemiparesis (weakness on one side of body), chronic pain, and depression. The Minimum Data Set Resident Assessment, dated 06/06/2024, revealed the resident was cognitively intact and required substantial to maximum assistance to roll left and right.</p> <p>Review of the current Comprehensive Care Plan, dated as revised 06/21/2024, and current Kardex (used by Certified Nursing Assistants to direct daily care) documented Resident #31 required assistance with mobility related to limited mobility, weakness, and left hemiplegia. Interventions included, but not limited to, substantial to maximum assistance to roll left and right with two staff assistance.</p> <p>During an interview on 08/18/2024 at 8:05 PM, Resident #31 stated the facility staff removed their side rails that they had used for a long time to move around in bed because they (the facility) considered them a restraint. Resident #31 stated after the siderails were removed, they fell out of bed, and they continue to be afraid of falling again.</p> <p>In a facility Accident/Incident Report and Incident Summary, dated 06/17/2024, Licensed Practical Nurse #2 documented Resident #31 had an observed fall on 06/16/2024 resulting in a brain bleed. Recommended steps to prevent recurrence was a therapy evaluation.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility Fall Risk Assessment Evaluation, dated 06/18/2024, revealed that prior to Resident #31's fall from bed on 06/16/2024 the resident had no history of falls in the prior six months.</p> <p>In a medical progress note, dated 06/17/2024, Nurse Practitioner #1 documented Resident #31 rolled out of bed while receiving care and was hospitalized resulting in a subarachnoid hemorrhage (brain bleed).</p> <p>A Rehabilitation Referral, dated 06/18/2022 (identified by the Director of Nursing as misdated and should have been dated 06/18/2024), signed by the Registered Nurse Supervisor included a referral to therapy to assess for adaptive equipment and/or assistive device due to a fall.</p> <p>Review of Resident #31's medical record did not include any evidence a therapy evaluation had been completed following the resident's fall with injury, or that a side rail assessment had been completed to determine the safety of one or the use of one for increased independence in bed mobility.</p> <p>During an interview on 08/23/2024 at 9:26 AM, Certified Nursing Assistant #1 stated Resident #31 had told them they were upset that their siderails were removed as they only had the use of one arm, and they could grab the siderails with that arm and move around and assist the aides with bed mobility as before.</p> <p>During an interview on 08/23/2024 at 9:44 AM, Unit Clerk/Certified Nursing Assistant #1 stated they had been caring for Resident #31 for many years and they used to have side rails which they used to help themselves roll, in addition to assisting the staff with bed mobility and positioning. The Unit Clerk/Certified Nursing Assistant #1 stated Resident #31 had a fear of rolling out of bed and the side rails also gave the resident peace of mind.</p> <p>During an interview on 08/23/2024 at 10:20 AM, Maintenance Staff #1 stated they were told side rails were not allowed and to remove them all (all side rails in the facility), and they guessed it came from the prior Administrator. Maintenance Staff #1 said they remembered Resident #31 saying they were unable to turn in bed without the side rails.</p> <p>During a telephone interview on 08/23/2024 at 10:28 AM, the Director of Maintenance stated they were ordered by the prior Maintenance Director to pull the side rails approximately 6 to 12 months ago, but did not get any information as to why, stating we just followed the work order.</p> <p>During an interview on 08/23/2024 at 10:38 AM, the Director of Nursing stated side rails were removed throughout (the facility) to stay in line for a restraint free facility and they were not aware Resident #31 had side rails prior to them being taken off their bed. The Director of Nursing stated no other type of bar had been considered to their knowledge and did not know if any side rail audit (assessment) had been completed. The Director of Nursing stated the therapy referral was dated as 06/18/2022 but should have been dated 06/18/2024. It should not have prevented therapy from completing a referral as the referrals were discussed in morning report and therapy checks their referrals on a regular basis.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/23/2024 at 11:15 AM, Occupational Therapist #1 stated this facility did not allow any side rails for any reason because they say they are a restraint. Occupational Therapist #1 said that a side rail on Resident #31's bed would not limit their freedom of movement and would not be considered a restraint for this resident. Occupational Therapist #1 said Resident #31 would actually be a very good candidate for a side rail due to their hemiparesis on one side and a strong arm on the other (to pull themselves over and hang on) and increase their participation with self-positioning and bed mobility (rolling to the side). Occupational Therapist #1 stated they did not put this information in their last therapy discharge note because the facility did not allow any side rails for any resident, and they were told by the Director of Nursing that they had to make a recommendation on Resident #31's Discharge Summary for the resident to participate in rolling to the side using strength of whole body (versus a side rail), despite their affected left side that was unable to yank or pull.</p> <p>During an interview on 08/23/2024 at 12:25 PM, the Administrator stated side rails were not a restraint if they were used appropriately.</p> <p>During an interview on 08/23/2024 at 2:09 PM, Physician #1 stated if the therapy department had made the recommendation for a bed mobility device the resident should be able to have one. Physician #1 stated they knew this resident used to have a siderail for self-positioning but was no longer allowed to have one due to the facility not allowing side rails any longer. Physician #1 stated if a resident had a cerebral vascular accident (stroke), had lost use of one side of their body, and had a strong opposite arm, a side rail or another device that could be added to the bed would help prevent them from rolling out of bed and there would be a less chance to fall with a barrier there.</p> <p>10 NYCRR 415.5(e)(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49368</p> <p>Based on interviews and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, for six (#52, #312, #313, #314, #315, and #317) of seven residents reviewed, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries at the termination of their Medicare coverage. Specifically, the facility did not provide a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) to Residents #314 and #315 and did not provide a Notice of Medicare Non-Coverage (NOMNC) to Residents #52, #312, #313, #317, and/or their representatives informing them of their appeal rights and/or their liability for services. This is evidenced by but not limited to the following:</p> <p>The Centers for Medicare & Medicaid Services (CMS) Form Instructions for the Notice of Medicare Non-Coverage Form CMS-10123 documented the Notice of Medicare Non-Coverage must be delivered at least two calendar days before Medicare covered services end.</p> <p>The Centers for Medicare & Medicaid Services Form Instructions Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage documented Medicare requires Skilled Nursing Facilities to issue the Skilled Nursing Facility Advance Beneficiary Notice to original Medicare beneficiaries prior to providing care, that Medicare usually covers, but may not pay in this instance because the care was not medically reasonable and necessary or considered custodial.</p> <ol style="list-style-type: none"> 1. Resident #52 was admitted to the facility on [DATE] under Medicare Part A services and discharged home on 08/13/2024. The Notice of Medicare Noncoverage was not provided to the resident and/or representative at least two calendar days before Medicare covered services ended. 2. Resident #312 was admitted to the facility on [DATE] and started Medicare Part A services on 05/01/2024 and discharged home on 06/27/2024. The Notice of Medicare Noncoverage was not provided to the resident and/or representative at least two calendar days before Medicare covered services ended. 3. Resident #314 was admitted to the facility on [DATE] and started Medicare Part A services on 02/01/2024 and ended services on 04/12/2024. The Skilled Nursing Facility Advance Beneficiary Notice was not provided to the resident and/or representative. Resident #314 remained in the facility receiving custodial care. 4. Resident #315 was admitted to the facility on [DATE] under Medicare Part A services and ended services on 03/05/2024. The Skilled Nursing Facility Advance Beneficiary Notice was not provided to the resident and/or representative. Resident #315 remained in the facility receiving custodial care. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0582</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/23/2024 at 3:25 PM, the Director of Admissions stated that residents receiving Medicare Part A services that required a Notice of Medicare Noncoverage were completed by the therapy department, and that the Director of Rehabilitation should be aware when a resident is discharged from therapy under Medicare Part A services to issue the Notice of Medicare Noncoverage and the Skilled Nursing Facility Advance Beneficiary Notice when applicable (resident remains in the facility under custodial care). The Director of Admissions stated that it was an oversight that some residents were not provided the Skilled Nursing Facility Advance Beneficiary Notice because the Director of Rehabilitation had thought those residents only required the Notice of Medicare Noncoverage.</p> <p>During an interview on 08/23/2024 at 3:36 PM, the Director of Rehabilitation stated they provide the Notice of Medicare Noncoverage at least 48 hours before a resident receiving Medicare Part A services ends, and they should provide the Skilled Nursing Facility Advance Beneficiary Notice (informing residents of their liability for services) if there were benefit days remaining and the resident remained in the facility. The Director of Rehabilitation stated that if the beneficiary (resident) intended to continue services and the facility believed the services may not be covered under Medicare, that it was the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.</p> <p>10 NYCRR 415.3</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00345323) from 08/18/2024 to 08/23/2024, for two (first and second floors) of two resident-use floors, the facility did not ensure a safe, clean, comfortable, and homelike environment. Specifically, there were roof leaks, missing ceiling tiles, and resident care equipment was dirty. The findings are:</p> <p>Record review of a roof vendor work estimate, dated 07/19/2024, revealed: roof repairs on the Ballasted EPDM (ethylene propylene diene terpolymer; a durable synthetic roofing membrane) roof system as needed in the active leak location on the South side of the building. The notes section of this report listed: Although work will be performed per proper roofing practices and we will stand behind our work, no guarantees can be provided on repair work due to the condition of the existing roof systems.</p> <p>Record review of an undated email communication from the Environmental Services Director to Corporate documented: The roof has been leaking above the second-floor day room for around a year. We applied a sealant which stopped the leaks. Just recently the leaks started again we set a plan in place (that included) drainage tarps and cans to catch the rainwater or divert it to a can. Starting Monday, the 26th of August we will start the roof repair in house.</p> <p>Record review of email communication from the Environmental Services Director to Corporate dated 07/25/2024, documented: I sent a proposal on possible roof repair. As of right know we have the leak under control but need the roofing company to come in and fix it permanently. The email response from Corporate on 07/31/2024, documented We have had some success repairing roofs in house using the two application silicone products.</p> <p>Observations on 08/19/2024 at 9:40 AM and 08/21/2024 at 9:00 AM included an oxygen concentrator was in use in resident room [ROOM NUMBER]-B (first floor) and had liquid spills, a buildup of dust, and debris on all surfaces.</p> <p>Observations on 08/19/2024 at 1:27 PM and 08/21/2024 at 9:38 AM included the oxygen concentrator in resident room [ROOM NUMBER]-A (first floor) was in use and covered with dust. During an interview at this time, Resident #76 stated that once a week they use a tissue to clean the vent so the machine does not overheat, and staff do not clean the machine.</p> <p>Observations on 08/19/2024 at 10:37 AM included an approximately 8-feet by 8-feet wide drainage tarp was installed in the suspended ceiling of the second-floor day room with multiple missing ceiling tiles. The drainage was observed to be going into a 32-gallon garbage can adjacent to the door to the day room. During an interview at this time, the Environmental Services Director stated the roof has been leaking and coming into the building on the second floor and has been an issue for over a year. The Environmental Services Director also stated that corporate wants to add a rubber sealant on to the roof and maybe some roof drains.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on 08/19/2024 at 10:40 AM included two missing 2-feet by 4-feet ceiling tiles in the suspended ceiling of the storage closet off the second-floor day room. Two trash cans were observed to be on the floor collecting water dripping from the ceiling. During an interview at this time, the Environmental Services Director stated the ceiling tiles were left open until the roof could be fixed and was not sure when it would be fixed.</p> <p>Observations on 08/19/2024 at 10:43 AM included five missing ceiling tiles and an approximately 2-feet by 2-feet tarp installed in the suspended ceiling within the second-floor nourishment room/nurses charting room. The drainage was observed to be going into a trash can and four other trash cans were on the floor collecting water leaking from the ceiling.</p> <p>When interviewed on 8/19/2024 at 10:43 AM, the Environmental Services Director stated the whole area around the day room on the second floor has been an issue when it rains heavy, and the roof top mechanicals are installed on the roof over the day room area.</p> <p>Observations on 08/19/2024 at 10:46 AM included two sit to stand resident lifts (#44853 and #2658249) on the second floor with footrests that were rusty and covered in debris. During an interview at this time, the Environmental Service Director stated maintenance staff should clean and wipe down the lifts when doing their monthly electrical inspections, and the lift looked like it was missed and not cleaned.</p> <p>During an interview on 08/22/2024 at 11:09 AM, the Administrator stated that either Certified Nursing Assistants (CNA) or housekeeping should be cleaning the oxygen concentrators, and there is a policy, but the procedure is not clear at this point.</p> <p>10 NYCRR: 415.29, 415.29(b), 415.29(i)(2), 415.29(j)(1)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>20765</p> <p>Based on interviews and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, for 24 (Residents #1, #5, #22, #25, #27, #28, #37, #49, #58, #59, #61, #69, #73, #76, #79, #82, #83, #84, #85, #100, #109, #110, #161, #311) of 24 residents, the facility did not ensure that the baseline care plan (care plan developed within 48 hours of admission that includes the minimum healthcare information necessary to properly care for the immediate needs of the resident) was completed within the required timeframe and that a summary of the baseline care plan was provided to the resident and/or their representative. Specifically, for Residents #73 and #82, the facility could not provide evidence that a baseline care plan was completed within 48 hours of the resident's admission. For Residents #1, #5, #22, #25, #27, #28, #37, #49, #58, #59, #61, #69, #76, #79, #83, #84, #85, #100, #109, #110, #161, and #311, the facility could not provide evidence that a summary of the baseline care plan was provided to the resident and/or resident representative. The findings included, but were not limited to, the following:</p> <p>Review of the facility policy Care Plans-Baseline, dated January 2024, included the baseline care plan would be developed for each resident within forty-eight (48) hours of admission and used until the facility staff could conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. The resident and their representative would be provided a summary of the baseline care plan that included, but was not limited to, the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any services and treatments to be administered by the facility.</p> <p>1. Resident #73 had diagnoses that included dementia, depression, and hypertension (high blood pressure). The Minimum Data Set Resident Assessment, dated 06/07/2024, documented the resident had severely impaired cognition.</p> <p>Review of the electronic health record for Resident #73 did not include documented evidence that a baseline care plan had been completed and the facility was unable to provide additional evidence of its completion when requested.</p> <p>2. Resident #82 had diagnoses that included a neurocognitive disorder with Lewy bodies (a form of progressive dementia), pseudobulbar affect (a nervous system disorder that causes involuntary laughing and crying), and depression. The Minimum Data Set Resident Assessment, dated 07/05/2024, documented the resident had severely impaired cognition.</p> <p>Review of the electronic health record for Resident #82 did not include documented evidence that a baseline care plan had been completed and the facility was unable to provide additional evidence of its completion when requested.</p> <p>3. Resident #5 had diagnoses that included major depressive disorder, diastolic congestive heart failure (a long-term condition where the heart cannot pump blood well enough to give the body a normal blood supply), and hypertension (high blood pressure). The Minimum Data Set Resident Assessment, dated 07/10/2024, documented the resident was cognitively intact.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the electronic health record for Resident #5 did not include documented evidence that a summary of the baseline care plan was provided to the resident and/or their representative and the facility was unable to provide additional evidence that the summary had been provided when requested.</p> <p>4. Resident #85 had diagnoses that included diabetes, epilepsy (a brain condition that causes recurring seizures), and schizophrenia (a mental disorder characterized by hallucinations and delusions). The Minimum Data Set Resident Assessment, dated 06/10/2024, documented the resident was cognitively intact.</p> <p>Review of the electronic health record for resident #85 did not include documented evidence that a summary of the baseline care plan was provided to the resident and/or their representative and the facility was unable to provide additional evidence that the summary had been provided when requested.</p> <p>During an interview on 08/22/2024 at 12:25 PM, the Social Worker stated baseline care plans were completed by nursing and social work was not involved in the process. The Social Worker stated they provided information to include in the baseline care plan, and if something stood out about a resident, they would add it to the care plan.</p> <p>During an interview on 08/23/2024 at 1:57 PM, the Administrator stated some residents' data was located in the electronic health record system that was previously used by the facility, however, when they looked in that system for the identified residents, they did not have a baseline care plan.</p> <p>During an interview on 08/23/2024 at 5:50 PM, with the Director of Nursing and Administrator, both stated they were not aware of any issues regarding the completion of baseline care plans or summaries being provided to the resident and/or resident representative.</p> <p>10 NYCRR 415.11</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46526</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey and complaint investigation (NY00338206) from 08/18/2024 through 08/23/2024, for one (Resident #5) of ten residents, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Specifically, Resident #5 was observed over several days with debris underneath their fingernails including while eating. This is evidenced by the following:</p> <p>The facility policy Care of Fingernails/Toenails, dated January 2024, documented that nail care included daily cleaning and regular trimming. The policy included to remove dirt from around and under each nail.</p> <p>Resident #5 had diagnoses that included muscle weakness, depression, and arthritis. The Minimum Data Set Resident Assessment, dated 07/10/2024, revealed Resident #5 was cognitively intact, had highly impaired vision, and required moderate assistance with personal hygiene.</p> <p>Review of the current Comprehensive Care Plan and Kardex (care plan used by Certified Nursing Assistants for daily care) included that Resident #5 was legally blind, required moderate assistance with personal hygiene, and maximal assistance with bathing.</p> <p>Review of the Care Plan Meeting form, dated 07/23/2024, revealed Resident #5 had a history of refusing to get out of bed and often refused linen changes. It did not include mention of nail care refusals.</p> <p>During observations on 08/19/2024 at 9:14 AM, Resident #5 had dark debris underneath all their fingernails.</p> <p>During observations on 08/21/2024 at 9:23 AM, Resident #5 continued with dark debris underneath multiple nails on both hands.</p> <p>During observations and interview on 08/22/2024 at 8:40 AM, Resident #5 was in bed with a bowl of cereal. Resident #5 had debris underneath fingernails on the left hand and was using the left hand to touch their cereal. During an interview at that time, Resident #5 said they use their hands to eat because they cannot see, and staff do not assist them with hand hygiene prior to meals.</p> <p>During an observation on 08/22/2024 at 12:25 PM, the resident had debris underneath multiple nails of their left hand. At 12:43 PM, Resident #5 was touching various food items on their lunch tray with their left hand.</p> <p>During an observation on 08/23/2024 at 10:42 AM, Resident #5 had debris underneath the multiple nails on both hands.</p> <p>Review of Interdisciplinary Progress Notes from 07/01/2024 to 08/23/2024 did not include documented evidence that Resident #5 was offered or refused nail care.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Documentation Survey Report (used to track completion of resident care tasks) from 08/01/2024 to 08/23/2024 did not include documented evidence that Resident #5 was offered or refused nail care.</p> <p>During an interview on 08/23/2024 at 10:47 AM, Certified Nursing Assistant #5 said they assist residents with nail care and the Activities staff polish residents' nails. Certified Nursing Assistant #5 said there is a green bag of hand wipes that are used for residents (to perform hand hygiene) who had meals in the dining room, but they did not know if hand washing or a hand wipe were offered to residents who had meals in their rooms. Certified Nursing Assistant #5 said nail care should be provided when residents' nails were long or if dirty but this was not documented when provided. Certified Nursing Assistant #5 stated they had cared for Resident #5 for several days. The resident had impaired vision, so they told the resident where items on their plate were located. Certified Nursing Assistant #5 said they had not assisted Resident #5 with handwashing prior to breakfast that morning and the resident used their hands to eat. Certified Nursing Assistant #5 said they saw that Resident #5 had debris underneath their nails but had not provided nail care due to being rushed.</p> <p>During an interview on 08/23/2024 at 11:08 AM, Licensed Practical Nurse Manager #1 said on shower days, nails should be cleaned and trimmed if long or jagged. If debris was observed underneath a resident's fingernails, it should be cleaned at any time. If a resident refused nail care, the staff should notify the unit manager. When observed at that time, Licensed Practical Nurse Manager #1 said Resident #5's fingernails were dirty and they would clean them.</p> <p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing said nail care was done as a part of the resident's shower, but unkempt (dirty) or sharp fingernails should be addressed even if it was not a resident's designated shower day.</p> <p>10 NYCRR 415.12(a)(3)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (Resident #59 and #71) of two residents reviewed. Specifically, Resident #59 was readmitted from the hospital on 08/06/2024 following surgical treatment of an abscess (a painful, swollen lump filled with pus) and did not have a follow up evaluation as ordered in a timely manner. Resident #71, who had a contracture (a shortening of muscles, tendons, skin, and nearby soft tissues that prevent normal joint movement which is often painful) of the left hand did not have a care plan in place that included measurable goals, interventions, or monitoring which resulted in multiple pressure ulcers and a decrease in range of motion. This resulted in actual harm to Resident #71 that was not Immediate Jeopardy and is evidenced by the following:</p> <p>1. Resident #71 had diagnoses that included a stroke and hemiparesis (weakness or the inability to move on one side of the body). The Minimum Data Set Resident Assessment, dated 05/31/2024, documented the resident was cognitively intact, had a functional limitation in range of motion in one upper extremity and one lower extremity, and did not have any pressure ulcers.</p> <p>The facility policy Contracture Management Program, dated January 2024, documented the facility will engage residents as appropriate in contracture management interventions to improve, maintain, and prevent deterioration of the mobility of joints, flexion, and extension of extremities. Relevant care plans will be initiated that address resident risks and actual impairments and interventions to address.</p> <p>The facility policy Resident Mobility and Range of Motion, dated January 2024, documented residents with limited range of motion will receive treatment, services, and equipment to increase and/or prevent further decrease in range of motion. The resident care plan will be developed by the interdisciplinary team based on the comprehensive assessment, will be revised as needed, and will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and range of motion. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.</p> <p>Review of an Occupational Therapy Discharge Summary, dated 10/11/2023, the Director of Therapy documented Resident #71 had a contracture to their left hand and their splint (a device used to treat a contracture that provides support, improves range of motion, prevents pain and impairment to skin integrity) was missing, a new one was ordered, and the resident would continue therapy treatment once the splint arrived. The facility was unable to provide evidence Resident #71 received a splint or any occupational therapy services since 09/28/2023.</p> <p>There was no documented evidence Occupational Therapy readmitted Resident #71 to resume therapy services.</p> <p>Review of the current Comprehensive Care Plan and Kardex (a care plan used by Certified Nursing Assistants to provide daily care) did not include information related to Resident #71's contracture to their left hand or interventions and monitoring for the contracture to prevent complications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a progress note, dated 08/18/2024 at 8:37 PM, included Registered Nurse Supervisor #1 documented Resident #71 had three new pressure ulcers on their left hand due to the contracture. Two of the wounds were a stage two (partial thickness tissue loss as a shallow open ulcer) pressure ulcers, with the larger wound measuring three centimeters by one centimeter and one wound was considered an unstageable (full thickness tissue loss and wound base covered with dead tissue) pressure ulcer. The medical provider was notified, and verbal orders obtained for wound treatments and a follow-up with the facility wound care doctor.</p> <p>During observations on 08/18/2024 at 8:38 PM and 08/19/2024 10:42 AM, Resident #71's left hand was contracted and had open wounds of the left palm. There was no splint or dressing to the hand. During an interview at that time, Resident #71 stated the contracture had been there for a while, and they were not receiving any interventions or therapy for the contracture despite asking for therapy for two months.</p> <p>Review of a medical progress note, dated 08/18/2024, following a telemedicine visit Nurse Practitioner #2 documented the resident was being seen for multiple wounds to the left-hand contracture. Nurse Practitioner #2 ordered bacitracin (antibiotic ointment to help prevent infection) daily for three days and a wound consultant on 08/19/2024.</p> <p>There was no documented evidence a wound consult was ordered or completed.</p> <p>Review of a progress note, dated 08/19/2024 at 8:15 AM, the Director of Nursing documented Resident #71 had increased resistance to range of motion of their left hand, altered skin integrity, and an occupational therapy evaluation had been requested.</p> <p>Review of a physician's order, dated 08/19/2024, included to cleanse the left palm wound with normal saline, apply a thin layer of bacitracin, and cover with a dry dressing daily until 08/22/2024. The orders did not include orders for therapy services, or a follow-up visit with the wound doctor.</p> <p>During additional observations on 08/20/2024 at 10:18 AM and again at 2:29 PM, Resident #71 did not have a dressing covering the wounds to their left hand or any splint in place.</p> <p>Review of the August 2024 Treatment Administration Record revealed the left-hand wound treatment was signed off as completed on 08/19/2024 and 08/20/2024.</p> <p>During observations on 08/21/2024 at 1:05 PM, Occupational Therapist #1 was assessing Resident #71's left hand in the resident's room. There was no dressing in place to the left hand. During an immediate interview, Occupational Therapist #1 stated the resident had a contracture to their left-hand that required therapy.</p> <p>Review of an Occupational Therapy evaluation and assessment notes, dated 08/21/2024 and 08/22/2024, revealed the resident was being evaluated for increased pain that limited movement, decreased range of motion, decreased strength, and the need for splinting and passive range of motion, and that occupational therapy services were warranted.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/22/2024 at 9:37 AM, Certified Nursing Assistant #3 stated Resident #71 had a left-hand contracture for at least nine months and was unable to move their hand. Certified Nursing Assistant #3 stated Resident #71 had verbalized they wanted therapy to help with their left hand, but had not received any therapy during that time that they knew of.</p> <p>During an interview on 08/22/2024 at 2:04 PM, Occupational Therapist #1 stated Resident #71 was a high risk for contractures due to having a stroke and was surprised that Resident #71 did not have any interventions in place for contractures. The Occupational therapy department should have followed up and obtained a splint for Resident #71 based on the previous discharge summary, and was surprised it had been so long since occupational therapy had seen the resident. Occupational Therapist #1 stated Resident #71's left hand wounds were most likely caused by pressure from the contracture and the lack of interventions in place to keep the contracture from worsening and to protect the skin from breakdown.</p> <p>During an interview on 08/22/2024 at 4:15 PM, Physician #1 stated Resident #71 had contractures on the left side of their body, including the left hand, most likely a result of paralysis after their stroke. Physician #1 stated they would expect Resident #71 to be receiving interventions for the contracture including therapy services, range of motion exercises, and a device in their hand to help prevent skin breakdown. Physician #1 stated not receiving interventions for the contracture or therapy services could have led to the development of the pressure ulcers in Resident #71's hand.</p> <p>During an interview on 8/22/2024 at 5:25 PM, the Director of Nursing stated Resident #71 should have a care plan for the hand contracture that included interventions to prevent worsening of the contracture and prevent the development of a pressure ulcer. The Director of Nursing stated therapy should have been involved with the resident between their discharge on 09/28/2023 and the development of the pressure ulcers on 08/18/2024 and involved in quarterly assessments and care planning, but there was not a process in place for those evaluations. The Director of Nursing stated without a care plan with interventions for the contracture and the lack of involvement from occupational therapy, it most likely is what caused Resident #71 to develop pressure ulcers in the left hand.</p> <p>2. Resident #59 had diagnoses that included hemiplegia (partial or complete paralysis on one side of the body), protein-calorie malnutrition, and an abscess (a painful, swollen lump filled with pus) of the buttock. The Minimum Data Set Resident Assessment, dated 05/08/2024, documented the resident was cognitively intact.</p> <p>Review of the Comprehensive Care Plan, dated 08/12/2024, revealed Resident #59 had a surgical incision to the right buttock. Interventions included to apply treatment per the physician's order, weekly documentation of the wound, and referral to appropriate medical specialists as needed for evaluation and treatment.</p> <p>Review of a nursing progress note, dated 07/30/2024 at 5:35 AM, Registered Nurse #1 documented Resident #59 had requested to see a nurse and reported having a boil on the back of their right hip. The wound was assessed and found to be inflamed with signs of infection, and the resident was transferred to the hospital.</p> <p>Review of a hospital History and Physical, dated 07/30/2024 at 4:17 PM, revealed Resident #59 had gluteal (buttocks region) abscess and a Computed Tomography (CT) scan noted a fluid collection that was suggestive of an abscess.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>A hospital Discharge Summary and After Visit Summary, dated 08/6/2024, included Resident #59 was seen by surgical services while hospitalized and underwent an Incision and Debridement (I&D) surgical procedure on 07/31/2024 and wound closure on 08/02/2024, was being discharged on [DATE], and had a post-operative appointment scheduled with General Surgery on 08/13/2024.</p> <p>Review of a Readmission Note, dated 08/06/2024 at 3:13 PM, the Assistant Director of Nursing documented Resident #59 was readmitted to the facility.</p> <p>Review of physician's orders, dated 08/08/2024, included to cleanse the right buttock surgical wound with sterile water or normal saline, place a normal saline soaked gauze to the open area, apply skin prep (liquid skin protectant) to the peri-wound (surrounding skin), and cover with a silicone foam bordered dressing daily. An order, dated 08/06/2024, included an appointment scheduled for 08/13/2024 at 10:00 AM with the hospital general surgeon.</p> <p>During observations on 08/22/2024 at 11:47 AM, the wound was approximately three to four inches long. The lower portion of the wound incision closed with three sutures and the upper portion was a circular in shape open area. During an immediate interview, Registered Nurse #2 stated they would have the physician come look at the wound due to a possible dehiscence (the reopening of a surgical incision that had been stitched or stapled closed).</p> <p>Review of interdisciplinary progress notes from 08/06/2024 to 08/23/2024 did not include any documented evidence the Surgeon's office or any medical provider had evaluated the surgical wound following the resident's return to the facility.</p> <p>During an interview on 08/22/2024 at 2:43 PM, Registered Nurse Supervisor #2 stated they had spoken with the Director of Nursing who said Resident #59 was not being followed by a Wound Care Consultant because the resident was scheduled for a surgical follow-up appointment, but the appointment had been cancelled. Registered Nurse Supervisor #2 stated the facility's physician was assessing the resident's wound at that time.</p> <p>During an interview on 08/22/2024 at 4:59 PM, the Director of Nursing stated when Resident #59 returned to the facility from the hospital, a portion of the incision was not sutured closed (left open). The Director of Nursing stated residents were typically seen by the facility's Wound Care Consultant after surgical follow-up appointments. Resident #59's surgical appointment that had been scheduled for 08/13/2024 had to be changed to 09/12/2024 and Unit Clerk #1 (who schedules appointments) would know more about it.</p> <p>During an interview on 8/22/2024 at 5:53 PM, Licensed Practical Nurse Manager #1 stated Resident #59's surgical follow-up appointment had been rescheduled by Unit Clerk #1 but was not sure why. Licensed Practical Nurse Manager #1 stated the appointment should have been left as scheduled. The Wound Care Consultant had not been asked to see Resident #59 since their re-admission and the surgical follow-up appointment was now scheduled for 09/12/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/23/2024 at 9:49 AM, Unit Clerk #1 stated their role involved setting up resident appointments and scheduling transportation. Resident #59 had an appointment scheduled for 08/13/2024 with the surgeon, but they had to reschedule it for transportation reasons. Unit Clerk #1 stated there were three residents scheduled for outside appointments on 08/13/2024, they could not get medical transport for all three residents, and Resident #59's appointment is now scheduled for 09/12/2024. Unit Clerk #1 stated they did send an email to Licensed Practical Nurse Manager #1 about Resident #59's appointment change but they had only been in their role for about two months and had not been told during training that someone (in leadership) should be notified if an appointment needed to be rescheduled or why.</p> <p>During interviews on 08/23/2024 at 02:17 PM and again at 04:41 PM, Physician #1 stated the facility used Wound Care Consultants (physicians) to assess residents with wounds and provide recommendations and as far as they knew, Resident #59 had not been seen by a Wound Care Consultant (following their surgery and readmission). Physician #1 stated follow-up appointments were important because the surgeon would recommend the treatment course, and they (facility staff) should be notified if an appointment was rescheduled or cancelled. Physician #1 stated rescheduling Resident #59's appointment could impact the resident due to a delay in treatment (not getting the surgeon's recommended treatment) and the resident could get an infection. Physician #1 said they observed Resident #59's wound on 08/22/2024 and the wound looked the same compared to their previous observation (no date provided), and they do not believe it had dehisced (the reopening of a surgical incision that had been stitched or stapled closed).</p> <p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing stated Unit Clerk #1 was responsible for resident appointments and if an appointment needed to be rescheduled or cancelled, it should be discussed with the unit manager and notify the physician. The Director of Nursing did not know the why Resident #59's 08/13/2024 appointment had been rescheduled, and a special request for a Wound Care Consult had now been made since the surgical follow-up appointment had been rescheduled (for 09/12/2024).</p> <p>10 NYCRR 415.12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>20765</p> <p>Based on observations, interviews, and record reviews conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, for one (Resident #16) of one resident, the facility did not ensure the resident received treatment and/or assistive devices to maintain hearing. Specifically, Resident #16 was hard of hearing, had a documented request to be seen for hearing aids, and the facility did not arrange for an audiology (hearing) evaluation. This is evidenced by the following:</p> <p>Resident #16 had diagnoses including diabetes, depression, and bilateral hearing loss. The Minimum Data Set Resident Assessment, dated 07/03/2024, included the resident was cognitively intact, was able to hear with minimal difficulty, and did not have hearing aids.</p> <p>During an interview on 08/19/2024 at 10:24 AM, Resident #16 stated when they were admitted , they were told the facility would help them get hearing aids. They were seen to get their ears cleaned and sent to a hearing specialist, but still had not been evaluated for hearing aids. Resident #16 stated their inability to hear affects them daily and makes them feel isolated because they cannot hear anything that is going on around them and cannot participate in most activities. Resident #16 stated they would purchase their own hearing aids if they could afford them, but was told the facility would help them.</p> <p>Review of the current Comprehensive Care Plan revealed the resident had a hearing deficit, hearing loss, and impacted cerumen (a condition that occurs when too much earwax builds up in the ear canal). Interventions included to refer to audiology for a hearing consult as ordered.</p> <p>Review of a Care Plan Meeting form, dated 05/24/2023, revealed after discussion with the resident's family they did not want the resident to have hearing aids.</p> <p>Review of a Care Plan Meeting form, dated 10/10/2023, revealed Resident #16 was hard of hearing which made it difficult to communicate with them at times. The resident would be seen by an otolaryngologist (ear, nose, and throat doctor) for possible hearing aids as they lost a pair due to not remembering to take them out or put them in.</p> <p>Review of a Care Plan Meeting form, dated 04/03/2025, revealed Resident #16 had reported to nursing they would like to get hearing aids.</p> <p>During an interview on 08/23/2024 at 12:57 PM, Medical Records Staff #1 stated they had previously worked as the Unit Clerk on Resident #16's unit and had received an order, around early April 2024, for Resident #16 to be seen by audiology for hearing aids. They stated they tried to speak to Resident #16 about making the appointment, but they were unable to hear them, so they contacted the appointed family member. Medical Records Staff #1 stated the family member said they were not going to pay for the resident to get new hearing aids because they had previously come up missing. Medical Records Staff #1 made the former Director of Nursing and former physician aware via email.</p> <p>During an interview on 08/23/2024 at 5:45 PM with the Administrator and Director of Nursing, the Administrator stated they were not aware Resident #16 wanted to be evaluated for hearing aids and they would have the Unit Clerk get a quote for hearing aids and present it to the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.12(a)(3)(b)(1-3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49447</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigations (NY00338206 and NY00337318) from 08/18/2024 to 08/23/2024, the facility did not ensure that appropriate treatment and services were provided to prevent urinary tract infections for a resident with an indwelling urinary catheter (tube inserted into the bladder to drain urine into a drainage bag) for one (Resident #25) of one resident reviewed. Specifically, Resident #25 had a history of urinary tract infections and was observed on multiple occasions with their urinary catheter drainage bag, catheter drainage port, and catheter tubing lying directly on the floor without a barrier, and with the drainage bag completely full of urine resulting in a backup of urine in the tubing. This is evidenced by the following:</p> <p>Resident #25 had diagnoses including [NAME] disease (a rare genetic disorder that affects the kidneys), neuromuscular dysfunction of the bladder (the bladder does not work properly causing an inability to urinate), and urinary tract infections. The Minimum Data Set Resident Assessment, dated 06/20/2024, documented the resident was cognitively intact, had an indwelling urinary catheter, had a urinary tract infection in the last 30 days, and that Resident #25 did not refuse care.</p> <p>The Comprehensive Care Plan and Kardex (care plan used by the Certified Nursing Assistants for daily care) included catheter care every shift, perineal (groin) care every shift, and monitor for signs and symptoms of a urinary tract infection.</p> <p>Hospital discharge summaries dated 01/17/2024, 06/17/2024, and 07/17/2024 documented Resident #25 was treated for a urinary tract infection. Treatment included replacing the urinary catheter that was dislodged from the bladder and intravenous (via a vein) antibiotics.</p> <p>Review of current physicians' orders revealed an order for catheter care every shift.</p> <p>During an observation on 08/18/2024 at 8:37 PM, Resident #25's foley drainage bag was completely full of urine resulting in a backup of urine in the tubing. During an interview at this time, Resident #25 stated they were experiencing abdominal pain.</p> <p>During observations on 08/20/2024 at 2:19 PM and 08/21/2024 at 9:34 AM and again at 3:52 PM, Resident #25's foley drainage bag, drainage spout, and tubing were laying on the floor with no protective barrier.</p> <p>During an interview on 08/22/2024 at 9:06 AM, Certified Nursing Assistant #3 stated they were responsible for performing catheter care each shift, draining the drainage bag, and making sure the drainage bag was not on the floor. They stated if they found the drainage bag on the floor, they would hang it back up off the floor. Certified Nursing Assistant #3 stated the Resident #25's foley drainage bag was frequently found on the floor and that the Kardex did not include instructions to keep the drainage bag off the floor.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/22/2024 at 3:53 PM, Licensed Practical Nurse #1 stated they are responsible for catheter care that included emptying the drainage bag. Licensed Practical Nurse #1 stated urinary catheter drainage bags should never be on the floor or be completely full of urine backing up the tubing. This is due to infection control, so the resident does not develop a urinary tract infection.</p> <p>Review of Resident #25's treatment administration records for 06/01/2024 through 08/22/2024 revealed that on 23 shifts the catheter care was not signed off as provided as ordered.</p> <p>During an interview on 08/22/2024 at 4:15 PM, Physician #1 stated the most common complication from a urinary catheter is a urinary tract infection. Physician #1 stated Resident #25 was at an increased risk for a urinary tract infection related to having a urinary catheter, and not emptying the drainage bag and having urine back up the tubing and letting the drainage bag touch the ground without a barrier all would increase that risk and potentially cause a urinary tract infection.</p> <p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing stated documentation not signed off as completed could mean the care was not done. The Director of Nursing said urinary catheter drainage bags should be emptied at least every shift and before it is so full urine is backing up. Drainage bags should never be on the floor, and catheter care should be completed as ordered and at least every shift. The Director of Nursing stated catheter care, emptying the drainage bag, and keeping it off the floor are to prevent urinary tract infections.</p> <p>10 NYCRR 415.12(d)(1)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>46526</p> <p>Based on observations, interviews and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, for one (Resident #59) of one resident reviewed for tube feedings (nutrition administered via a tube inserted directly into the stomach via the abdomen due to the residents' inability to consume food and drink by mouth), the facility did not provide appropriate treatment and services to prevent potential complications. Specifically, there was no documented evidence that Resident #59's total daily intake of tube feedings was being monitored to ensure their nutritional needs were being met, physician's orders regarding administration of the tube feedings while consuming food were unclear, and free water flushes and nutritional supplements were not administered as ordered by the physician. This is evidenced by the following:</p> <p>The facility policy Enteral Nutrition (method of supplying nutrition directly into the gastrointestinal tract), dated reviewed January 2024, included that the enteral nutrition would be ordered by the physician based on the recommendations by the dietician. The dietician, with input from the physician and nurse, would estimate calorie, protein, nutrient, and fluid needs; determine whether the resident's current intake is adequate to meet their nutritional needs; recommend special food formulations; and calculate fluids to be provided (beyond free fluids in formula). Additionally, the nurse would confirm that there were appropriate orders for oral (PO) intake or restrictions for nothing by mouth (NPO), as appropriate.</p> <p>1. Resident #59 had diagnoses that included hemiplegia (partial or complete paralysis on one side of the body), protein-calorie malnutrition, and dysphagia (difficulty swallowing). The Minimum Data Set Assessment, dated 05/08/2024, included that the resident was cognitively intact, had a feeding tube and was on a mechanically altered diet.</p> <p>Review of the Comprehensive Care Plan included to administer tube feeding and water flushes per the dietician's recommendation(s) and physician's orders, and for the dietician to evaluate quarterly, and as needed, by monitoring caloric intake and estimated needs.</p> <p>Current physician orders included:</p> <p>a. Administer Jevity 1.5 (tube feed formula) via gastrostomy tube (G-tube-a tube that is surgically inserted through the stomach wall and into the stomach in which to administer nutrition) at a rate of 90 milliliters an hour to begin at 8:00 PM and disconnect at 12:00 PM with a total volume of 1440 milliliters infused daily.</p> <p>b. Administer 150 milliliters of water via gastrostomy tube every three hours, five times a day, for a total volume of 750 milliliters.</p> <p>c. Regular diet, ground texture and thin consistency - to take Resident #59 to the dining room for meals to eat under nursing supervision. (ordered 08/19/2024 for quality of life.)</p> <p>d. Juven (nutritional supplement) packet via gastrostomy tube three times a day.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no order indicating if Resident #59's tube feedings should be stopped during meals.</p> <p>During observations on 08/21/2024 at 10:05 AM, Resident #59 was observed in their room, connected to their tube feeding pump infusing Jevity 1.5 at 90 millimeters an hour and a bag of water at 151 milliliters of water flushes every two hours (versus 150 milliliters every 3 hours as ordered).</p> <p>During observations on 08/22/2024 at 7:45 AM, Resident #59 was in the dining room and was disconnected from their tube feeding. During an interview at the time, Registered Nurse #2 said Resident #59 was disconnected from their tube feeding and would be reconnected after breakfast and a dressing change. At 9:05 AM, Resident #59 remained not connected to their tube feeding. At 11:45 AM, Resident #59 was connected to the tube feeding via the pump which was programmed to infuse the tube feeding at 90 milliliters of Jevity 1.5 every hour and the water was infusing at 150 milliliters every six hours (versus every three hours as ordered).</p> <p>During observations on 08/23/2024 at 10:38 AM and at 11:41 AM, Resident #59 was again disconnected from their tube feeding.</p> <p>Review of Medication Administration Records for 08/07/2024 to 08/23/2024 revealed documentation that Resident #59 's tube feeding was administered from 8:00 PM continuously to 12:00 PM and the water flushes were documented as administered 150 millimeters daily at 1:00 AM, 4:00 AM, 7:00 AM, 10:00 AM, and 10:00 PM, despite the observations of the tube feeding being off during the same time frame and the water flushes programmed incorrectly. The Juven nutritional supplement was not signed off as administered on 35 of 49 opportunities with reasons being documented as not available, not in stock, or not received from pharmacy. There was no documentation of the total volume of tube feeding actually administered each day (taking into consideration the observations of the tube feeding being off).</p> <p>There was no documented evidence that the medical team had been notified that the Juven nutritional supplement had been unavailable.</p> <p>During an interview on 08/23/2024 at 11:43 AM, Licensed Practical Nurse Manager #1 said the nurses who hang the tube feeding during the night should make sure the pump settings matched the physician orders. Licensed Practical Nurse Manager #1 said Resident #59's tube feeding order was to start at 8:00 PM and turn off in the morning with 90 milliliters an hour for 16 hours for a total volume of 1440 milliliters. Licensed Practical Nurse Manager #1 said the pump (with the set total volume of 1440 milliliters) should let the nurses know (by beeping) when 1440 milliliters had been administered. Licensed Practical Nurse Manager #1 stated there should be an order (if decided on by the dietician and the physician) to stop the tube feeding during meals, but did not believe there was one for Resident #59. Licensed Practical Nurse Manager #1 stated staff told them that Resident #59 wanted their tube feeding off during breakfast, so they disconnected it, and were not sure why it was off again except because it was lunchtime and the resident was eating. After review of the resident's Medication Administration Record with the surveyor, Licensed Practical Nurse Manager #1 said there were packets of Juven in the medication cart but if the nurses did not have it, they should notify pharmacy or dietary and call the medical team to get an order for something else, or hold the medication and document.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/23/2024 at 1:36 AM, Certified Dietician #1 said they document monthly on residents with tube feedings which includes the ordered tube feeding and (water) flushes. Certified Dietician #1 said they could not find the total amount of tube feeding that was actually administered, and if they did not have a documented amount of tube feeding given to compare to the total volume ordered, then they could not determine if the resident had received the ordered amount to meet their nutritional needs. Certified Dietician #1 said Resident #59 was receiving food strictly for pleasure and the tube feed was based on 100 percent of their nutritional needs. Certified Dietician #1 stated stopping the tube feeding during meals would require a physician's order.</p> <p>During an interview on 08/23/2024 at 2:17 PM, Physician #1 said the nurses are responsible for ensuring the resident received the total volume tube feeding as ordered. Physician #1 stated there would be an order to hold the tube feeding during meals (if that was intended). Physician #1 said the majority of Resident #59's nutrition is provided via the feeding tube and the food items provided (at meals) are for the resident's pleasure. Physician #1 said staff are taking Resident #59 to the dining room, where they are watched by the nurse during meals, but no one told them staff were stopping the tube feeding during meals.</p> <p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing stated there should be a medical order to hold (disconnect) a tube feeding during a meal. The Director of Nursing stated the process for ensuring the resident received the tube feeding as ordered consisted of it being on the pump and completing the tube feeding once 1440 milliliters had been administered (as ordered). The Director of Nursing stated if a medication was not available, staff should notify Pharmacy and medical provider, and document this.</p> <p>10 NYCRR 415.12(g)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>46526</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 08/19/2024 to 08/23/2024, for one (Resident #85) of three residents, the facility did not ensure residents who needed respiratory care were provided such care consistent with professional standards of practice. Specifically, Resident #85 was observed wearing oxygen via a nasal cannula (a device that delivers oxygen through a person's nose), did not have a physician order in place for oxygen use via a nasal cannula, and there was no documentation in the Medication Administration and Treatment Administration Records that reflected the use of oxygen via nasal cannula each shift. This is evidenced by the following:</p> <p>The facility policy Oxygen Administration, dated January 2024, included to verify and review a physician's order for oxygen administration.</p> <p>Resident #85 had diagnoses that included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (disorder in which breathing stops and starts repeatedly during sleep), and pneumonia. The Minimum Data Set Resident Assessment, dated 06/10/2024, revealed Resident #85 was cognitively intact and received continuous oxygen therapy.</p> <p>Review of the current Comprehensive Care Plan included Resident #85 used a continuous positive airway pressure (CPAP- a machine that delivers continuous air while a person is sleeping) and had shortness of breath when lying flat. Interventions included to provide oxygen per physician's orders and to maintain and change the oxygen tubing per protocol.</p> <p>Review of current physician's orders did not include the use of oxygen via nasal cannula.</p> <p>Review of a Provider Progress Note, dated 06/07/2024 at 2:34 PM, Physician #2 documented Resident #85 was admitted to acute care (hospital) for pneumonia and a chronic obstructive pulmonary disease exacerbation (symptoms become more severe) which required continuous oxygen supplementation. The assessment and plan included to continue around the clock oxygen requirements at baseline.</p> <p>Review of a Progress Note, dated 08/16/2024 at 7:17 PM, Physician #1 documented Resident #85 had been on 3.5 liters per minute of oxygen via nasal cannula. They decreased the oxygen to 2.5 liters per minute, which Resident #85 said felt better.</p> <p>Review of the Medication Administration and Treatment Administration Records from 08/01/2024 to 08/23/2024 did not include documentation that reflected Resident #58 's use of oxygen via nasal cannula each shift.</p> <p>During observations on 08/22/2024 at 11:33 AM, Resident #85 was in their room, wearing a nasal cannula with oxygen set at 2.5 liters per minute. During an interview at that time, Resident #85 said they had worn oxygen for quite some time including since they had been readmitted to the facility from the hospital on 06/06/2024. Resident #85 said facility staff told them the oxygen was to be worn as needed and was recently sent out to an appointment without oxygen on.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During observations on 08/23/2024 at 11:04 AM, Resident #85 was in their room wearing a nasal cannula with oxygen set at 2.5 liters per minute. During an interview at that time, Resident #85 said they were on oxygen all the time and facility staff never told them they did not require oxygen.</p> <p>During an interview on 08/23/2024 at 11:18 AM, Licensed Practical Nurse #3 said if a resident used oxygen, a physician's order was required, and nurses would ensure the resident's oxygen settings matched the order. Licensed Practical Nurse #3 said there was usually an order on the electronic Treatment Administration Record where the nurse could enter how much oxygen the resident was on per shift.</p> <p>During an interview on 08/23/2024 at 11:43 AM, Licensed Practical Nurse Manager #1 said Resident #85 was a resident on the unit that wore oxygen as needed. When the electronic medical record was reviewed at that time, Licensed Practical Nurse Manager #1 said there was no order for oxygen via nasal cannula in place for Resident #85. They said there should be an order for oxygen to include how much oxygen, how long it was to be worn (e.g., continuous, at bedtime, as needed, etc.), how it was provided (e.g., mask, nasal cannula, etc.), and nurses should document if the oxygen was on or not. Licensed Practical Nurse Manager #1 said it was possible that staff forgot to reorder oxygen for Resident #85 when they were readmitted from the hospital.</p> <p>During an interview on 08/23/2024 at 2:17 PM, Physician #1 said oxygen did require an order. They would tell the nurse how much oxygen the resident should receive, the nurse would enter the order in the electronic health record, and the physician would confirm the order. Physician #1 said they had decreased Resident #85's oxygen from three liters per minute to 2.5 liters per minute, and while the resident had sleep apnea and used oxygen at bedtime, they had not seen the resident wear oxygen during the day.</p> <p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing said oxygen use did require a physician's order and did not know why there was not an order in place for Resident #85's oxygen via nasal cannula. The Director of Nursing said Resident #85 was supposed to use continuous positive airway pressure, but the resident did not wear it. The Director of Nursing said prior to their hospitalization, Resident #85 wore oxygen at night because they did not have a continuous positive airway pressure machine.</p> <p>10 NYCRR 415.12(k)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>20765</p> <p>Based on observations, interviews, and record review conducted during a Recertification Survey from 08/18/2024 to 08/23/2024, the facility did not ensure the nurse staffing information was posted daily and included the required information. Specifically, the facility did not post the accurate nurse staffing data on 08/18/2024, 08/20/2024, 08/21/2024 or 08/22/2024, as required per the regulations. This is evidenced by the following:</p> <p>During an observation on 08/18/2024 at 8:30 PM, the daily nurse staffing information was not visibly posted.</p> <p>During observations on 08/20/2024 at approximately 11:15 AM, 08/21/2024 at 10:29 AM, and 08/22/2024 at 9:04 AM, the posted daily nurse staffing information was dated 08/19/2024.</p> <p>During an interview on 08/21/2024 at 10:29 AM, Receptionist #1 stated Scheduler #1 was responsible for printing the daily nurse staffing information. Scheduler #1 was on vacation and no one else had printed the daily nurse staffing information.</p> <p>During an interview on 08/23/2024 at 9:41 AM, the Assistant Director of Nursing stated Scheduler #1 was responsible for posting the daily nurse staffing information. The Assistant Director of Nursing stated they were unsure of the process for the daily nursing staffing postings.</p> <p>During an interview on 08/23/2024 at 9:47 AM, the Director of Nursing stated Scheduler #1 worked Monday through Friday from 7:00 AM to 3:00 PM and would occasionally work on the weekends. The Director of Nursing stated they were responsible for posting the daily nurse staffing when Scheduler #1 was not working, and the nursing supervisors would be responsible for posting the information on off shifts.</p> <p>Scheduler #1 was unavailable for an interview during the survey.</p> <p>10 NYCRR 415.13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>49447</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, the facility did not ensure that all drugs and biologicals were properly stored in accordance with State and Federal Laws for two (Unit One Hall A and Unit Two Hall A) of two medication carts and one (Unit Two) of two medication rooms reviewed. Specifically, medication carts contained expired medications, insulin without an open or expiration date, and one bottle of eye drops without any resident identifiers. Additionally, the medication room contained expired medications. This is evidenced by but not limited to the following:</p> <p>The undated facility policy and procedure, Storage of Medications, included drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.</p> <p>During an observation on 08/21/24 at 4:45 PM, the Unit Two Hall A medication cart had four bottles of medications that were open and in use, including one bottle of fish oil that expired June 2024, one bottle of Vitamin C and one bottle of Vitamin D3 that expired July 2024, and one bottle of cetirizine hydrochloride (allergy medication) that had no expiration date printed on the bottle. Additionally, there was one Lantus (long-acting) insulin pen in use with no open or expiration date on it.</p> <p>During observations on 08/21/2024 at 5:02 PM, the Unit Two medication room had five bottles of expired medications including two bottles of bisacodyl (laxative) that expired February 2024, one bottle of fish oil that expired April 2024, one bottle of fish oil that expired June 2024, and one bottle of Vitamin C that expired July 2024. Additionally, the medication refrigerator had two boxes of bisacodyl suppositories that expired February 2024, nine doses of the influenza vaccine that expired 06/10/2024, and one open box of acetaminophen suppositories that expired June 2024. During an interview at that time, Licensed Practical Nurse Manager #1 stated no expired medications should be stored in either the medication carts or the medication room, and the expired medications should have been found during night shift audits that were completed by the nurses.</p> <p>During observations on 08/22/2024 at 12:52 PM, the Unit One Hall A medication cart had one bottle of artificial tears eye drops that had no resident identifiers and no open or expiration date, one vial of insulin lispro (short-acting) and one vial of insulin glargine (long-acting) that were in use and not labeled with an open or expiration date, one bottle of simethicone (used to treat gas and bloating) that expired June 2024, and a vial of insulin glargine that was in use and had expired on 08/01/2024. During an interview at that time, Licensed Practical Nurse #1 stated each resident-specific medication should have a label that included resident identifiers, and insulin and eye drops should be labeled with an open and expiration date.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/23/2024 at 4:49 PM, the Director of Nursing stated resident-specific medications should be labeled with resident identifiers, insulin and eye drops should be labeled with open and expiration dates, and no expired medications should be stored in medication carts, medication rooms, or medication refrigerators. The Director of Nursing stated audits were being completed monthly on the medication carts and included checks for expired medications, expiration dates on medications, and resident identifiers. The identified medications must have been missed during the audits.</p> <p>10 NYCRR 415.18(e)(1-4)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46526</p> <p>Based on observations, interviews, and record review conducted during the Recertification Survey from 08/18/2024 to 08/23/2024, for one of one main kitchen, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, non-food contact surfaces were dirty, utensils and dishware were dirty, floors were dirty, there was missing grout between floor tiles, a reach-in cooler was dirty, and food items were not stored 6 inches above the floor. The findings are:</p> <p>Record review of the facility sanitization policy and procedure, dated 01/2024, listed 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair, 3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions.</p> <p>Observations in the main kitchen on 08/18/2024 between 6:42 PM and 7:16 PM included the following:</p> <p>a) Several juice containers, butter, a can of soda, and three crates of milk containing 10 half-gallon containers were stored directly on the floor in the walk-in cooler.</p> <p>b) There was a bag of vegetables and a bag of zucchini slices on the floor in the walk-in freezer underneath the shelves.</p> <p>c) The upright reach-in cooler was heavily soiled with food on the bottom shelves (loose cut up lettuce), dried food debris on ledges, dried food residue on gaskets, and the outside had dried food debris.</p> <p>d) There was a large amount of food crumbs in both sides of the base of the stainless plate warmer unit.</p> <p>e) There were food crumbs in the drawers that contained large utensils (spoons, scoopers, spatulas, etc.) and one #6 scooper had dried food debris on it.</p> <p>During observations on 08/19/2024 at 9:12 AM and 08/20/2024 at 11:50 AM, the upright reach-in cooler remained dirty with food crumbs and debris in bottom of cooler, including water puddles of cloudy water with white floating debris in them.</p> <p>During observations on 08/20/2024 11:45 AM, the kitchen floors under the ovens, storage racks, dish machine, and food preparation area were dirty with food spillage, debris, and grime. There was soiled rag stuffed into a drain line under the preparation sink. Additionally, most of the dish room floor was missing grout and there was stagnant water with food debris in the grooves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/20/2024 at 11:52 AM, the Acting Food Service Director/Registered Dietician stated the kitchen needed to be cleaner and a deep cleaning should take place at least weekly. The Acting Food Service Director/Registered Dietician also stated that the missing grout in the dish machine area has been an ongoing issue for years and they were not sure what the plan was to address it. The Acting Food Service Director/Registered Dietician stated that cleaning duties get divided up between different staff daily, and there were a lot of new people that were trying. The Acting Food Service Director/Registered Dietician also stated that hopefully when a new Food Service Director starts, we can get staff on board with training for cleaning and it will look like it used to.</p> <p>During an interview on 08/21/2024 at 4:00 PM, the Administrator stated the kitchen should be cleaner and needed be addressed. The Administrator also stated that they were in the middle of hiring a new Food Service Director as they had been without one for a month.</p> <p>10 NYCRR: 415.14(h),</p> <p>10 NYCRR: Subpart 14-1, 14-1.43(a), 14-1.95, 14-1.110(d), 14-1.170</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>34459</p> <p>Based on observations, interviews, and records review conducted during a Recertification Survey and complaint investigation (NY00345323) from 08/18/2024 to 08/23/2024, for one of one kitchen, the facility did not ensure there was an effective pest control program. Specifically, small brown flies and fruit flies were present and untreated. The findings are:</p> <p>The facility pest control policy dated 01/2024, documented the following: E. A complaint log will be maintained by the Maintenance Department. Whenever there is a complaint noted, a maintenance work order is to be sent to the Maintenance office. F. Monitoring of pest control is performed as part of the weekly environmental rounds conducted by Performance Improvement Committee designee, daily observations, and documentation by staff in the Maintenance/Engineering log located at all Nursing stations and Security Stations departmental rounds and preventative measures.</p> <p>Record review of the past three months of maintenance logs on units revealed no pest control concerns were noted by staff.</p> <p>Pest control vendor treatment records for the past three months documented the following:</p> <ul style="list-style-type: none"> - On 05/13/2024, all drains in the main kitchen and kitchenettes were treated to cut down on the current and ongoing drain fly issue. - On 05/21/2024, all internal drains throughout the building were treated including the kitchen. - On 06/03/2024, all interior drains were treated to cut down on drain fly activity including the kitchen and two kitchenettes. - On 06/08/2024, treated the drains in the kitchen and the first floor as well as second floor kitchenette with an aerosol cleaner and all the drains to cut down and attempt to prevent on going drain fly activity. Also informed customer that the staff need to clean a little bit better in the kitchen to continuously help with the drain activity. - On 07/09/2024, treated all of the drains with a foam cleaner to continuously prevent and cut down on drain fly activity. <p>Observations on 08/18/2024 at 6:34 PM included approximately 20 small, brown flies flying around flats of soda cans in the dry storage room within the main kitchen.</p> <p>Observations on 08/19/2024 at 3:47 PM and 8/20/24 at 11:52 AM included several small, brown flies in the dry storage room within the main kitchen.</p> <p>During an interview on 08/19/2024 at 3:47 PM, the Acting Food Service Director/Registered Dietician stated there were no current pest control issues they were aware of, and they believed the only preventative treatments were being done for ants.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Maple City Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 434 Monroe Avenue Hornell, NY 14843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/20/2024 at 11:30 AM, the Environmental Services Director stated they have not seen any flies and nothing was documented in maintenance logs that they saw.</p> <p>During an interview on 08/20/2024 at 11:52 AM, the Acting Food Service Director/Registered Dietician stated the kitchen was lacking in cleanliness and deep cleaning should take place at least weekly.</p> <p>During an interview on 08/21/2024 at 4:00 PM, the Administrator stated they were not aware of any pest control concerns.</p> <p>10 NYCRR: 415.29(j)(5)</p>