Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335361	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clifton Springs Hospital and Clinic Extended Care	2 Coulter Road Clifton Springs, NY 14432

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 47641 Based on interviews and record review conducted during the Recertification Survey from 11/07/2024 to 11/15/2024, for one (Resident #93) of nine residents reviewed, the facility did not ensure that the medical team was notified in a timely manner following a significant medication error. Specifically, the medical team was not notified timely when a medication had not been administered according to physician's orders resulting in potentially serious side effects. This is evidenced by the following: The facility policy Event Reporting revised October 2023, documented the definition of an error was a mistake in process that was made, regardless of impact to the patient, that should not have been present and caused harm. Examples of errors includes medication variances. Any error, close calsl, or other safety event should be reported and appropriate follow-up services as necessary. Resident #93 had diagnosis including hypertension (high blood pressure), transient ischemic attack (mini stroke), and myocardial infarction (heart attack). The Minimum Data Set Resident Assessment, dated 09/03/2024, documented the resident was cognitively intact and had orthostatic hypotention (low blood pressure with position changes). Medical orders, dated 07/24/2024 and signed by Nurse Practitioner #1, included midodrine for orthostatic hypotention 2.5 milligrams three times daily and to hold the medication if the resident's systolic blood pressure is greater than 140 or their diastolic blood pressure is greater than 80. Review of the resident's Medication Administration Record, dated 08/21/2024, documented midodrine 2.5 milligram tablet was administered at 9:20 PM. Review of the Default Flowsheet Data (vital signs record) in the resident's electronic medical record revealed on 08/21/2024 at 9:20 PM, Resident #93's blood pressure was 165/100. A progress note written by Registered Nurse #1 on 08/21/2024 at 9:28 PM documented Resident #93 received their midodrine 2.5 milligram tablet, their blood pressure was 165/100, and the supervisor was notified. A progress note written by Registered Nurse Clinical Leader #1 on 08/21/2024 at 9:33 PM documented they were notified Resident #93 was administered midodrine with a blood pressure of 166/98 and the provider was notified via a communication log (a book on the unit for staff to leave messages for the medical team to review the following day). (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note written by Licensed Practical Nurse #3 on 08/22/2024 at 2:45 AM documented the resident requested their blood pressure to be taken as they felt it was high and complained of nausea and feeling flushed. Resident #93's blood pressure was 198/116 which was rechecked 10 minutes later and was 188/118. Resident #93 began to complain of chest pressure and heart palpitations, the provider was notified, and the resident was transported to the emergency department. During an interview on 11/15/2024 at 9:23 AM, Registered Nurse Clinical Leader #1 stated nurses should let the provider know of medication errors as soon as they are aware of the error. If midodrine was given out of physician's parameters as ordered, the nurse should let the provider know right away as it could raise the resident's blood pressure even more than it already was. Registered Nurse Clinical Leader #1 said Resident #93's blood pressure should have been monitored. During an interview on 11/15/2024 at 11:20 AM, the Director of Nursing stated the communication log is seen by the provider the next day, writing the error in the communication log would not have notified the provider timely, and they were unsure why this was not done immediately. 10 NYCRR 415.3(f)(2)(ii)(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/15/2024, for three (Residents' #16, #43, and #86) of 23 residents reviewed, the facility did not develop and/or implement comprehensive person-centered care plans that included measurable goals and interventions to meet the residents' medical, nursing, and psychosocial needs as identified in their comprehensive assessments. Specifically, the comprehensive care plan for Resident #16 did not include goals or interventions related to their respiratory function and tracheostomy (a surgically created opening in the neck and into the windpipe to help with breathing and remove secretions). For Residents #43 and #86, the comprehensive care plan did not include measurable goals or interventions related to active skin impairments. This is evidenced by the following. Review of the facility policy Comprehensive Person-Centered Care Planning Process, dated March 2024, included a comprehensive person-centered interdisciplinary care plan will be developed for each individual receiving care, which includes measurable objectives and timetables to meet an individual's medical, nursing, nutritional, rehabilitative, cultural, psychosocial, and as applicable trauma informed needs and preferences that are identified in the comprehensive assessment. All Care Area Assessments that are triggered by the Minimum Data Set Assessment will require a care plan to be developed or an explanation in writing of why it was determined not to proceed. Care needs or risks identified through the Minimum Data Set process that do not trigger a Care Area Assessments will also require a care plan to be developed or an explanation in writing of why it was determined not to proceed. 1. Resident #16 had diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, and cerebral palsy (a group of neurological disorders that affect a person's ability to swallow, move, balance, and maintain posture). The Minimum Data Set Resident Assessment, dated 10/03/2024, documented Resident #16 was cognitively intact, had a tracheostomy and was on a mechanical ventilator (a medical device that helps a person breathe by moving air into and out of their lungs). Review of the current Comprehensive Care Plan did not include any measurable goals or interventions related to the resident's tracheostomy and ventilator use, monitoring of, or complications to monitor for. The current Interdisciplinary Care Card (care plan used by the Certified Nursing Assistants) included oxygen therapy with interventions to maintain oxygen saturation above 90%, to provide tracheostomy care in the AM and PM and as needed, and full ventilator support at night. During an interview on 11/15/2024 at 10:49 AM, Registered Respiratory Therapist #1 stated residents who have a tracheostomy and are on the ventilator should have their own person-centered care plan as the care and needs they have may be very different based on their individual needs. During an interview on 11/15/2024 at 11:06 AM, Registered Nurse Manager #1 stated Resident #16 should have a care plan specific to their respiratory needs that included the tracheostomy and ventilator, their specific problem, goals, and interventions including what staff should monitor and report. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #86 had diagnoses that included a stroke, chronic respiratory failure, and obesity. The Minimum Data Set Resident Assessment, dated 10/10/2024, documented the resident had severely impaired cognitive skills and a deep tissue injury. During an observation on 11/12/2024 at 11:09 AM, Resident #86 had an unstageable (wound unable to be staged due to the presence of dead tissue) pressure injury approximately one inch by one inch to the left buttocks. Review of the Comprehensive Care Plan and Interdisciplinary Care Card included interventions to prevent skin breakdown. The Care Plans did not include Resident #86 had a current pressure injury, goals, and/or interventions for monitoring the pressure injury, or reporting issues with the pressure injury. During an interview on 11/15/2024 at 11:06 AM, Registered Nursing Manager #1 stated Resident #86 had the skin breakdown since admission from the hospital (approximately a month ago) and had not been care planned for the skin impairment at that time nor when it worsened (10/17/2024). They also stated they should have implemented and started a care plan for the actual skin impairment at the time of admission and updated the care plan as needed. 3. Resident #43 had diagnoses that included meningioma (a benign tumor that grows in the membranes that surround the brain and spinal cord), mechanical ventilator dependence, and obesity. The Minimum Data Set Resident Assessment, dated 10/01/2024, documented the resident was moderately impaired of cognitive skills. During an observation on 11/07/2024 at 3:20 PM, Resident #43 had a quarter-sized, red, open skin impairment to the right temple. Review of Resident #86's electronic medical record revealed they had been followed by dermatology (skin doctor) since June 2021 for a lesion on the right side of the head that was potentially a basal cell carcinoma (skin cancer). Documented communication with Resident #86's family on 11/30/2021 revealed the family declined to biopsy the lesion and would continue conservative treatment. Review of the Comprehensive Care Plan and Interdisciplinary Care Card did not include that the resident had a skin lesion, goals, or interventions related to the skin impairment to the right temple, or potential skin cancer. During an interview on 11/15/2024 at 11:06 AM, Registered Nurse Manager #1 stated Resident #86 should have had a care plan for the skin lesion and potential skin cancer that included measurable goals and interventions for the lesion, what to monitor for, and when and to whom to report any changes or concerns. During an interview on 11/15/2024 at 10:42 AM, Certified Nursing Assistant #3 stated they used the Interdisciplinary Care Cards to know how to take care of each resident and everything they needed to know and monitor should be on the care cards. They also stated if they did not see something on the care card, they would not know what to do without asking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 10:35 AM, Licensed Practical Nurse #5 stated the Comprehensive Care Plans and the Interdisciplinary Care Cards are important because they tell you how to take care of each resident and the services and care they need. They stated the nurse manager completes the Comprehensive Care Plan. During an interview on 11/15/2024 at 11:55 PM, the Director of Nursing stated care plans should be created from the Minimum Data Set Resident Assessment as well as based off each resident's needs and history. They also stated each care plan needed to be specific to the resident and include the problem, measurable goals, and interventions. Additionally, residents with a tracheostomy and using a ventilator and residents with active skin impairments should have specific care plans for those issues. 10 NYCRR 415.11(c)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46526 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/15/2024, the facility did not ensure that services were provided to meet professional standards of quality for one (Resident #93) of two residents reviewed during medication administration pass. Specifically, Resident #93 had a medication signed off as administered but was omitted during the observed medication pass. Additionally, Resident #93 had multiple doses of a medication that had been signed off as administered, but were not administered, due to not being available, with no evidence that the medical team had been notified. This is evidenced by the following: The facility policy Medication Administration revised February 2020, included the six rights of medication administration as the right patient, right medication, right dose, right time, right route, and right documentation. Resident #93 had diagnoses that included stroke, diabetes, and constipation. The Minimum Data Set Resident Assessment, dated 09/03/2024, revealed Resident #93 was cognitively intact. Current physician's orders included polyethylene glycol 17 grams daily scheduled at 9:00 AM for constipation and brinzolamide (Azopt) 1% ophthalmic suspension one drop to the right eye three times a day ordered on 08/12/2024 for glaucoma and may use resident's own medication. The eye drops were scheduled for 9:00 AM, 1:00 PM, and 5:00 PM daily. During observation of medication administration pass on 11/13/2024 at 8:30 AM, Licensed Practical Nurse #1 stated Resident #93's brinzolamide eye drops were not available, the medication was not carried by the facility's pharmacy, and they were waiting for the resident's relative to pick it up and bring to the facility (from an outside pharmacy). Additionally, Licensed Practical Nurse #1 did not prepare and administer the polyethylene glycol dose scheduled to be given at 9:00 AM. Review of the Medication Administration Report from 11/05/2024 to 11/13/2024, revealed out of 25 opportunities for administration of brinzolamide eye drops, 19 opportunities were documented as not given, including all three doses on 11/07/2024, 11/08/2024, and 11/09/2024. Licensed Practical Nurse #2 documented that on 11/10/2024 and 11/11/2024, the 5:00 PM dose of the brinzolamide eye drops were administered but the 9:00 AM and 1:00 PM doses on those days were documented as not given, not available. Additionally, Licensed Practical Nurse #1 documented the polyethylene glycol dose on 11/13/2024 was administered at 8:42 AM. The brinzolamide was documented as not given. Review of Interdisciplinary Progress Notes, dated 11/01/2024 to 11/13/2024, revealed no documented evidence that a covering medical provider had been notified that Resident #93's brinzolamide eye drops were not available. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/2024 at 11:57 AM, Licensed Practical Nurse #1 stated if a medication was due to be given and was not available, they would indicate this in the electronic Medication Administration Record, send a message to Pharmacy that the medication was missing, and let Registered Nurse Clinical Lead #1 know the medication was unavailable. Licensed Practical Nurse #1 stated there should be documentation in the medical provider book (if the provider was notified of an unavailable medication), which they thought was done, but could not recall when. Licensed Practical Nurse #1 also stated they did not know how long the eye drops had been unavailable, and that the Assistant Director of Nursing was aware they were unavailable. Licensed Practical Nurse #1 stated they could not remember if they gave Resident #93 the polyethylene glycol (on 11/13/2024 during morning medication pass). Review of the medical provider book from 11/10/2024 to 11/13/2024 revealed no entries related to Resident #93's brinzolamide eye drops being unavailable. During an interview on 11/13/2024 at 12:27 PM, Registered Nurse Clinical Leader #1 stated entries in the medical provider book are usually shredded when they are a week old because there are a lot of entries. Registered Nurse Clinical Leader #1 stated they had trouble getting the brinzolamide eye drops, and they were not sure how long it had been unavailable, but they were working on it. During an interview on 11/14/2024 at 8:42 AM, Resident #93 stated they did not like to take the polyethylene glycol and had told them (nurses) that they do not want it. Resident #93 stated they received three different eye drops to their right eye and could not remember which eye drops were given. During an interview on 11/14/2024 at 4:26 PM, Licensed Practical Nurse #2 stated they worked the evening shifts on 11/10/2024 and on 11/11/2024, and did not give the brinzolamide eye drops and must have (accidently) documented them as given. During an interview on 11/15/2024 at 8:32 AM, the Assistant Director of Nursing stated when administering medications, the nurse should give the medication and then document it was given. They also stated if a medication was due to be given and it was unavailable, the nurse should attempt to find out why, contact the pharmacy to see if they could get it, and check the satellite pharmacy (Omnicell, an automatic medication dispensing machine). The Assistant Director of Nursing stated if a medication was consistently unavailable, the medical provider should be notified to see if something different (alternative medication) could be ordered. During an interview on 11/15/2024 at 11:21 AM, the Director of Nursing stated the nurses should document after a medication is given to the resident (to ensure accurate documentation) and should not expect a nurse to document that a medication was given if it was not administered. During an interview on 11/15/2024 at 12:01 PM, Nurse Practitioner #1 stated Resident #93 had come from the emergency room with the brinzolamide eye drops which the facility was going to use since they did not carry the medication. Nurse Practitioner #1 also stated they were not aware that Resident #93 had not been receiving the brinzolamide eye drops, and if they had been made aware, they would have ordered a comparable medication. 10 NYCRR 415.11(c)(3)(i)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 11/07/2024 to 11/15/2024, for one (Resident #16) of nine residents reviewed, the facility did not ensure each resident received adequate supervision to prevent accidents. Specifically, Resident #16 was identified to be a high risk for aspiration (accidental inhalation of food or drink into the airway) that required full supervision with meals and was observed not supervised at mealtime. This is evidenced by the following: The facility policy Aspiration Precautions/Dysphagia dated March 2024, included residents with dysphagia (difficulty swallowing) and/or at risk for aspiration are assessed and appropriate resident centered interventions are incorporated into the resident's care plan. Enteral feed/ventilator/tracheostomy residents must be on aspiration precautions and the care plan team will determine what mealtime supervision the resident requires, considering any recommendations from the speech therapist, and the registered nurse will add the mealtime supervision requirement to the care plan and care card. Resident #16 had diagnoses that included a stroke, dysphagia, and cerebral palsy (a group of neurological disorders that affect a person's ability to swallow, move, balance, and maintain posture). The Minimum Data Set Resident Assessment, dated 10/03/2024, documented Resident #16 was cognitively intact, had a tracheostomy (a surgically created opening in the neck and into the windpipe to help with breathing and remove secretions), and was on a mechanical ventilator (a medical device that helps a person breathe by moving air into and out of their lungs). Review of the physician orders, dated 09/03/2024, revealed a mechanically altered diet, no straws, nectar thick liquids, chopped meats, and that the resident had feeding guidelines. Review of the facility document Recommended Feeding Guidelines signed by Speech and Language Therapist #1 on 08/30/2024, revealed Resident #16 had multiple feeding recommendations including, but not limited to the following: 1. Mechanical soft diet with nectar thick liquids. 2. Out of bed for meals. 3. No straws. 4. Full supervision. 5. Set me up for oral care at least twice daily. 6. Encourage me to alternate solids/liquids. 7. Encourage me to use small bites/sips. 8. Encourage me to use a slow rate of intake. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Interdisciplinary Care Card (a care plan used by the Certified Nursing Assistants for daily care), dated 9/03/2024, included Resident #16 required full supervision for meals. During an observation on 11/12/2024 at 8:14 AM, Resident #16 was in a recliner chair in their room eating breakfast. No staff were in the room to provide supervision. During a continuous observation on 11/12/2024 from 11:42 AM to 12:17 PM, Resident #16 received their lunch tray, had their tray set up by a Certified Nursing Assistant, and ate their lunch. There were no nursing staff in the resident's room or visible in the hallway to provide full supervision during the meal. During an interview on 11/12/2024 at 11:58 AM and again at 12:59 PM, Certified Nursing Assistant #1 stated Resident #16 was on their assignment and they review the resident's care cards daily to review how to take care of each resident. They also stated the care cards included diet consistency and any guidelines or recommendations made by the speech therapist. Certified Nursing Assistant #1 stated full supervision would mean a staff member should be present with the resident for the entirety of the meal. They also stated they had not been in Resident #16's room during their meal, but should have been. During an interview on 11/12/2024 at 1:18 PM, Licensed Practical Nurse #4 stated Resident #16 had a history of aspiration, was a high risk for choking, and often needed to be suctioned after meals. Additionally, Resident #16 required full supervision for meals, the assigned Certified Nursing Assistant should have provided supervision per the care card, and the assigned nurse is responsible to ensure supervision is occurring. Licensed Practical Nurse #4 stated they were not aware Resident #16 had not received full supervision with their meals. During an interview on 11/15/2024 at 1:55 PM, Speech and Language Therapist #1 stated residents on the ventilator with a trach (tracheostomy) were at a very high risk for aspiration and were assessed by speech therapy to determine safety and develop recommendations and guidelines for feeding. Additionally, Resident #16 received a lot of speech therapy in order to eat, was at high risk for aspiration and potential complications related to aspiration, and needed to have a staff member in the room at all times while they were eating. Speech and Language Therapist #1 stated staff members should encourage and cue the resident to follow the speech therapy recommendations and guidelines and should observe for resident safety so they can respond promptly to any issues or concerns. During an interview on 11/15/2024 at 10:35 AM, Registered Nurse Manager #1 stated nursing staff are expected to follow the care plan and interdisciplinary care card including supervision with meals and speech therapy recommendations and guidelines. 10 NYCRR 415.12(h)(2)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49447 Based on observations, interviews, and record reviews conducted during a Recertification Survey from 11/07/2024 to 11/15/2024, the facility did not ensure the daily nurse staffing information was consistently posted to include the daily resident census, the total number and actual hours worked by the licensed and certified nurses at the beginning of each shift on a daily basis, and that they were readily accessible to residents and visitors. Specifically, the nursing staff information was not posted in a readily accessible location for all residents and visitors, the information was not completed or updated for night shift and on weekends, and the information posted was not updated or consistently accurate. This is evidenced by the following: The facility policy Long Term Care Nursing Services - Posting of Nurse Staffing Information dated October 2024, included the posting will include the total number and actual hours worked of licensed and unlicensed staff directly responsible for resident care per shift, the facility will post the nurse staffing data on a daily basis at the beginning of each shift, and the data will be posted in a prominent place readily accessible to residents and visitors. During observations on 11/07/2024 at 12:10 PM and 11/12/2021 at 11:01 AM, the posted nurse staffing numbers were located in the second-floor hallway prior to entering the 2200 resident care unit. Residents and visitors for resident care units 2300 and 2400 on the second floor and resident care units 3100, 3200, and 3300 on the third floor would not pass the posting or be able to visualize the posted nursing staffing unless going to the 2200 resident unit. Review of the posted daily nurse staffing information from 11/01/2024 to 11/13/2024 revealed 6 of 11 days did not include the accurate number of Licensed Practical Nurses and/or Certified Nursing Assistants when reviewed with the staffing schedules for those days. Review of the posted daily nurse staffing information from 08/01/2024 through 11/14/2024 revealed no documented evidence that the required nurse staffing information had been completed for any weekends during that time. During an interview on 11/12/2024 at 1:32 PM, the Nursing Staffing Coordinator stated they are responsible for completing the posted nursing information and posting the information. They stated they complete the information for all shifts and update day shift and evening shift as needed; they do not update the night staffing information. The Nursing Staffing Coordinator also stated the posted staffing is not updated for the night shift and is not completed when they are not in the building (weekends or vacations). The Nursing Staffing Coordinator stated the information is not easily accessible to residents and visitors on the third floor or for resident care units 2300 and 2400. During an interview on 11/15/2024 at 11:55 AM, the Director of Nursing stated they are not involved with the posted nursing information and were not aware of any issues with the postings. During an interview on 11/15/2024 at 12:18 PM, the Operations Supervisor stated they occasionally help cover the posting when the Nursing Staffing Coordinator is not available, and were not aware of any issues with updating or posting the information. (continued on next page)

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