

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/05/2025
NAME OF PROVIDER OR SUPPLIER  The Pines at Utica Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  1800 Butterfield Ave Utica, NY 13501	

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 - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (iQIES ID# 2648127), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one (1) of three (3) residents (Resident #1). Specifically, Resident #1 had physician orders discontinuing their Unna boots (gauze bandage soaked in a wound treatment, wrapped from toes to knees that provided compression and remained in place for up to one week) on 10/03/2025, and there was documented evidence the Unna boots remained in place for seven (7) days without an order and without monitoring. On 10/10/2025, the resident complained of left leg pain and upon removal of the Unna boot, they were found with a new open wound on the left outer ankle that contained an infestation of maggots. Additionally, there was no documented evidence the resident's wounds were assessed timely upon admission and no documented evidence a physician ordered treatment was obtained timely. This resulted in harm that was not Immediate Jeopardy for Resident #1. Findings included: There was no documented evidence the facility had a policy that addressed non-pressure injury wounds. The resident had diagnoses including lymphedema (accumulation of lymphatic fluid in the body causing swelling), morbid obesity and difficulty walking. The 09/02/2025 admission Minimum Data Set (a resident assessment tool) documented the resident's cognition was intact; they needed substantial assistance with rolling left and right and partial/moderate assistance with chair/bed-to-chair transfer. The resident had three (3) venous ulcers (open sores that develop on the lower legs due to poor blood circulation). The 08/27/2025 Hospital Discharge Report documented the resident had multiple wounds (the report did not specify type, number, location or treatment). The 08/27/2025 admission Assessment completed by Wound Registered Nurse #1 documented the resident had a skin issue present. There was no documented evidence wound type, number of wounds, or location of wounds were identified, and there was no physician ordered treatment for wounds upon admission to the facility on [DATE]. The 08/27/2025 Comprehensive Care Plan documented the resident had an alteration in skin integrity with venous ulcers. Interventions included: monitor for signs and symptoms of infection, treatments as ordered, and weekly wound evaluations. The 08/29/2025 Skin and Wound Evaluation completed by Wound Registered Nurse #1 documented: - a venous ulcer, right top foot second toe, present on admission, 2 centimeters long x 1.2 centimeters wide, light serous drainage. - a venous ulcer, right front lateral (to the side of) lower leg, present on admission, 13.8 centimeters long x 5.2 centimeters wide, no drainage and intermittent pain. - a venous ulcer, left front lateral lower leg, present on admission, 6.2 centimeters long x 4.2 centimeters wide, no drainage, erythema (redness) in surrounding tissue and intermittent pain. Physician orders documented: - On 08/29/2025, Unna boots to right and left legs. - On 08/30/2025, to right foot (toe) wound, apply Xeroform (wound treatment) and bordered dressing daily. - On 09/01/2025, Unna boots to right and left legs applied every Monday for wound healing. There was no documented evidence the resident's wounds were assessed from 08/30/2025 through 09/23/2025. The 09/24/2025 Skin and Wound Evaluation completed by Wound Registered Nurse #1 and signed on 09/26/2025, documented the resident's left front lateral and right front lateral leg wounds resolved. From 09/24/2025 through 10/02/2025, the resident's physician ordered Unna boots continued as ordered. The 09/2025 Treatment Administration Record documented Unna boots were applied to the resident's left and right legs weekly with the last documented administration on 09/29/2025 by Licensed Practical Nurse #7. The 10/03/2025 physician orders documented to discontinue routine and as needed Unna boots. The notes section of the physician order for Unna boots documented resolved. There was no documented evidence the Unna boots were removed after 10/03/2025. The 10/06/2025 Nurse Practitioner #5 note documented the resident was assessed and observed in their wheelchair with dressings intact to both feet. The 10/07/2025 Skin and Wound Evaluation by Registered Nurse Manager #4 documented the resident's right second toe was assessed. A picture of the resident's right foot was attached to the evaluation. The picture showed the resident's right foot toes to just below the right ankle, and a pink tinged gauze bandage wrapped around the resident's foot (later revealed in interview with Wound Registered Nurse #1 this was an Unna boot). There was no documented evidence of current physician orders in the resident's record for Unna boots on 10/07/2025. The 10/10/2025 Director of Nursing note documented they were called to assess the resident's left lower extremity. It was noted the resident had a new wound to the lateral left lower extremity that was found to have small maggots noted. The site was cleansed with saline</p>		