STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335374	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025 - 7/22/2025, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (5) of five (5) residents (Residents #2 #11, #13, #17 and #80) reviewed. Specifically:Resident #11's urinary catheter (drains urine from the bladder) collection bag was directly on the ground without a barrier, and the resident did not have appropriate transmission-based precaution signage posted.Registered Nurse Unit Manager #5 did not wear appropriate personal protective equipment when providing central line catheter (intravenous access site) care to Resident #2.Resident #13 had a urinary catheter and a colostomy (a surgical opening from the bowel for collection of stool) and did not have appropriate transmission-based precaution signage posted.Resident #17 had nephrostomy (drains urine from the kidneys) tubes and a catheter and did not have appropriate transmission-based precaution signage posted.Resident #80 had a contact isolation sign posted on their door with no available gowns and gloves. Housekeeping entered the room without donning gown and gloves.Findings include: Findings include:The facility policy Clinical Services: Precautions to Prevent Infection, revised 6/2024, documented transmission-based precautions were for patients who were known or suspected to be infected or colonized with infectious agents. Enhanced barrier precautions was an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of infections when contact precautions did not apply. The category of transmission-based precaution determined the type of personal protective equipment and should be readily available at the entry of the room. Residents who had indwelling medical devices such as central lines, urinary catheters would be on enhanced barrier precautions. Gown and gloves were to be worn for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Clear signage was posted on the resident's door indicated type of precaution and required personal protective equipment. Residents with indwelling medical devices or wounds would have enhanced barrier precautions remain in place until resolution of wound or discontinuation of indwelling medical device. The facility policy Clinical Services: Urinary Catheterization, revised 4/2024, documented enhanced barrier precautions are indicated for residents with indwelling catheters. The catheter should be replaced if there are breaks in aseptic technique, disconnections of tubing, leakage from the bag, if catheter becomes contaminated. The drainage bags should always be covered and placed below the level of patient's bladder. The outlet valve must not be contaminated. 1) Resident #2 had diagnoses including osteomyelitis (bone infection) of the right foot/ankle and extended spectrum beta lactamase resistance (a bacteria enzyme resistant to antibiotics). The 6/9/2025 Minimum Data Set assessment documented the resident had intact cognition and had central intravenous access. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders documented: 5/16/2025 resident was to have care done in room due to isolation precautions. 6/4/2025 contact precautions. During an observation and interview on 7/16/2025 at 12:08 PM, Resident #2 had an orange contact precaution sign on their room door and a 3-drawer plastic bin filled with blue gowns, gloves, masks, and shields outside their room. Resident #2 stated nurses usually wore a gown and gloves when they provided wound care but never when they provided care for the central line. At 3:03 PM Registered Nurse Unit Manager #5 performed a central line dressing change without donning a gown. During an interview on 7/22/2025 at 10:09 AM, Certified Nurses Aid #7 stated they knew a resident was on precautions by the sign on the door. The sign informed staff what type of personal protective equipment was needed and when to wear it. For enhanced barrier precautions staff could go into the room without a gown or gloves but needed to put them on if doing hands on care. Resident #2 was on contact precautions, which meant a gown and gloves should be worn every time so that infection did not spread. During an interview on 7/22/2025 at 10:33 AM, Licensed Practical Nurse #4 stated the sign on the resident's door let staff know if the resident was on precautions. The Unit Manager decided who was on precautions and put the sign up. Resident #2 was on contact precautions for an infection in their foot. It was confusing to determine what to wear to go into their room because they had multiple different precaution type signs on their door. They went into the room with just a mask and gloves and put on a gown when they provided care. A gown should be worn every time if the resident was on contact precautions. During an interview on 7/22/2025 at 11:30 AM, Registered Nurse Unit Manager #5 stated Resident #2 was on contact precautions for a wound infection, which meant all staff entering their room were required to wear a gown and gloves. The resident did have multiple precaution signs on their door which was very confusing to staff. Staff may not know what sign to follow, with enhanced barrier precautions staff needed to wear a gown and gloves when providing care, and with contact precautions they needed a gown and gloves every time the room was entered. They stated did not wear a gown and gloves when changing the central line dressing for Resident #2, which increased the risk of spreading infection. 2) Resident #17 had diagnoses including renal abscesses (collection of pus), osteomyelitis (bone infection), and discitis (inflammation of spinal disc). The 5/12/2025 Minimum Data Set assessment documented the resident had intact cognition, required maximum assistance or was dependent for most activities of daily living, and had an ostomy and indwelling catheter. The Comprehensive Care Plan initiated on 1/2/2025 documented the resident required enhanced barrier precautions due to an indwelling urinary catheter and nephrostomy tube. Physician orders did not include enhanced barrier precautions. During an observation on 7/16/2025 at 11:40 AM, Resident #17 had no transmission-based precaution signage posted and no personal protective equipment readily available outside their room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/22/2025 at 11:30 AM, Licensed Practical Nurse Unit Manager #18 stated residents were supposed to be on enhanced barrier precautions if they had a wound, catheter, or any opening in their body. They were unsure if Resident #17 was on precautions prior to 7/17/2025 and they did not hang the enhanced barrier precautions signage outside their room. 3) Resident #11 had diagnoses including end stage renal disease, extended spectrum beta lactamase resistance, and heart disease. The 6/26/2025 Minimum Data Set documented the resident had severely impaired cognition, required minimal to moderate assistance for most activities of daily living, and had an indwelling catheter (drains urine from the bladder). The Comprehensive Care Plan initiated 9/18/2024 and revised 9/27/2024 documented the resident had an indwelling urinary catheter. Interventions included have enhanced barrier precautions and the urinary collections bag was to be kept off the floor. The following observations were made: On 7/16/2025 at 11:29 AM, Resident #11's urinary catheter bag was lying directly on the floor mat without a barrier. On 7/16/2025 at 2:39 PM, Resident #11's urinary catheter bag was dragging on the floor behind the resident in the hallway. On 7/16/2025 at 3:38 PM, enhanced barrier precautions signage was posted on or near Resident #11's door and there was no personal protective equipment readily available at the entrance of the resident's room. During an interview on 7/22/2025 at 10:34 AM, Licensed Practical Nurse #13 stated staff should wear a gown and gloves for enhanced barrier precautions. A central line and a urinary catheter were considered indwelling devices and required enhanced barrier precautions. A gown and gloves should be worn when providing central line care to a resident on enhanced barrier precautions. They stated they did not wear a gown and gloves when they provided care to Resident #11 because there was no signage or personal protective equipment cart at the door. Resident #17 had a urinary catheter and a nephrostomy tube and should have been on enhanced barrier precautions, but there was not a sign on their door. During an interview on 7/22/2025 at 11:42 AM, the Infection Prevention Consultant stated there were enhanced barrier precautions and contact precautions. Enhanced barrier precautions were for any resident with a urinary catheter, wound, or central line and staff would know a resident was on precautions because a sign was placed outside their room by the Infection Prevention Consultant or nursing supervisor. A cart with personal protective equipment was centrally located on the unit and for contact precautions the cart would be at the resident's door. The nursing supervisor or licensed practical nurse on the unit should check every shift to ensure the carts were stocked. Enhanced barrier precautions protected the resident and the staff member. A resident diagnosed with clostridium difficile would be on contact precautions because spores could land anywhere in the resident room; you would not want to get spores on your clothing and spread it to other residents. When care was provided for residents on enhanced barrier or contact precautions, gowns and gloves had to be worn. Before entering a resident's room staff should read the signage, wash their hands, and put on appropriate personal protective equipment. 10 NYCRR 415.19(a)(b)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review during the recertification survey conducted 7/16/2025-7/22/2025 the facility did not develop and implement an effective discharge planning process that focused on the resident's discharge goals for one (1) of three (3) residents (Resident #17) reviewed. Specifically, Resident #17 expressed the intention to be discharged to the community and was not updated on the status of their discharge plan.Findings include:The facility policy Admission, Discharge Policy, revised 6/2025, documented the discharge planning process began prior to admission during the pre-admission evaluation. Upon admission, the Team Based Assessment was completed by the interdisciplinary team to establish discharge plan and goals. Once the patient's goals for discharge were established and a date has been set that was amenable to the patient the social worker would coordinate necessary services, to include referrals to community resources.Resident #17 has diagnoses including renal (kidney) abscesses, osteomyelitis (infection) of vertebra, and discitis (infection and inflammation of spinal disc). The 5/12/2025 Minimum Data Set assessment documented the resident had intact cognition, had moderately severe depression, had no behavioral symptoms, required maximum assistance or was dependent for most activities of daily living, and there was no active discharge planning occurring for the resident. The 1/3/2025 Comprehensive Care Plan documented the resident had the need for a safe and appropriate discharge plan to return home. The resident's discharge goal was to discharge to the community. Interventions included to assess the discharge needs beginning on the day of admission, at the initial care plan meeting, and throughout the stay, and to assess learning needs and barriers toward discharge planning. The 1/29/2025 Team Based Assessment Weekly Discharge Plan completed by Case Manager #9 documented during a 1/2/2025 meeting it was determined the resident did not live alone and resided with their spouse, required assistance of two, needed skilled care for nephrostomy tubes (drains urine directly form the kidney), pressure wounds, and surgical wounds. The resident needed training on nephrostomy care. The resident had 5 stairs to enter their home, had durable medical equipment in the home, and required moderate assistance of two for dressing and transferring. The expected discharge location was home. The update on 1/16/2025 documented the resident required 2-person assistance and was unable to ambulate. The 1/22/2025 update documented it was unsure if the resident was able to be discharged home due to their living conditions. The 1/29/2025 update documented the resident's expected date of discharge was 2/28/2025.The 3/4/2025 Care Conference assessment documented the resident, and their family member were in attendance. The resident expressed an interest in attending therapy and wanting to be up in their chair more. There was no updated documentation regarding the resident's discharge plan The 4/8/2025 Team Based Assessment Weekly Discharge Plan completed by Case Manager #9 documented the resident required total assistance of two for transfers and dressing. The 2/19/2025 discharge plan update documented the resident's discharge plan was unclear. On 2/26/2025 the discharge plan update was unclear due to the resident's progress and the resident had a care plan meeting the next week to discuss a plan. The resident's needs did not exceed home health services and the resident's family did not verbalize discomfort with the resident's discharge timeline or resources. The resident's anticipated discharge date was 5/8/2025.The 4/9/2025 Case Manager #9 progress note documented they spoke with the Veteran's Administration social worker regarding the resident's discharge plan. They informed the Veteran's Administration social worker the resident would likely require long term care. The resident did not meet the Veteran's Administration's criteria for long term care. A plan was to be discussed at the resident's next care plan meeting.The 4/17/2025 Case Manager #9 progress note documented the resident exhausted their Medicare Part A benefit.The 4/22/2025 Social Services Director progress note documented they met with the resident per their request. The resident had inquired what their discharge plan was. The resident was receiving intravenous antibiotics three times a day and would (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not be able to manage them on their own at home. The resident also acknowledged they were unable to ambulate which was needed to be able to return home. The resident was agreeable to complete their intravenous therapy then see if they were able to return home.The 5/27/2025 care conference assessment documented the resident and responsible party were invited but did not document attendance. The resident had good pain management, and their nephrostomy tube was draining without difficulty. The resident was participating more in activities. The social services section documented the resident had potential for additional surgeries and did not wish to be long term care.There was no further documentation regarding discharge planning for the resident or working toward the resident's desired goal of returning home. During an interview on 7/16/2025 at 11:40 AM, Resident #17 stated things had not been going well since their Medicare ran out 3 months ago. They had no therapy since then and they needed more therapy to be able to go home. The resident stated no one was helping them to work toward their goal of going home. During an interview on 7/21/2025 at 9:38 AM, Resident #17 stated they were tired not getting physical therapy to be able to go home. During an interview on 7/21/2025 at 1:23 PM, Case Manager #9 stated if a resident wanted to discharge but needed additional services, they would look at getting the resident managed long term plan caregiving services. If a resident wanted therapy, they let the therapy and nursing department know so nursing could put in a screen and notes to support the need for therapy services. Therapy would then screen the resident to decide if the resident would benefit from a therapy program. Resident #17 wanted to be discharged but needed 24-hour care that could not be provided by the family. The resident was previously on the second and moved to the fourth floor under their caseload a couple of months ago. They did not discuss options for returning home with Resident #17. At the time of their last care conference, the resident needed to stay in the facility because they were on intravenous antibiotics. They did not follow up with the resident regarding discharge planning since then and the resident had a quarterly care plan meeting coming up. They typically waited until the quarterly care conferences to have those conversations as the resident had not asked to speak with them. During an interview on 7/22/2025 at 10:34 AM, Licensed Practical Nurse #13 stated Resident #17 was constantly asking about their discharge and about getting therapy. They did not know what the resident was told about their discharge plan, but they were aware the resident was admitted for short term rehabilitation. They told the Unit Manager about the resident's wish for therapy and discharge.During an interview on 7/22/2025 at 12:10 PM, the Director of Rehabilitation stated if a resident expressed the want for therapy services, nursing should document the rational and put in a screen for therapy to review. Therapy would screen to determine if therapy was appropriate for a resident. Therapy required a screen from nursing in to assess the resident. They did not receive a screen for Resident #11 since they came off therapy services on 4/11/2025.During an interview on 7/22/2025 at 12:23 PM, the Director of Social Services stated discharge planning started the day of admission, and the initial assessment was completed. If a resident could not fully participate due to cognition, they involved the resident's family. If a resident needed 24-hour care they would look at insurance to cover a personal aide. They were aware Resident #17 wanted to discharge from the facility, and they were working to get Medicaid in place. It was not safe for the resident to discharge home without caregivers due to their care level. The resident exhausted their Medicare A benefit. They had a care plan meeting on 5/27/2025 and the resident was to have surgeries for their nephrostomy tubes. The resident made them aware they did not want to be long term care. They stated the resident had some follow ups in the middle of June and they should have followed up with the resident after that. They should not wait until the quarterly care conference to discuss discharge planning with the resident.10NYCRR 415.11(d)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025- 7/22/2025, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for three (3) of three (3) residents (Residents #2, #6 and #50) reviewed. Specifically, Resident #6 did not have a comprehensive care plan for the use of anticoagulants (blood thinners); Resident #2 did not have a comprehensive care plan for managing their peripherally inserted central catheter (intravenous line); and Resident #50 did not have bilateral floor mats as care planned.Findings include:The facility policy Baseline/Comprehensive Person-Centered Care Plans, revised 3/2023, documented the person-centered care plan was developed to include information necessary to properly care for the resident and was reviewed and revised quarterly, following a significant change, annually, following a hospital readmission, and as needed. The care plan was kept current by all disciplines on an ongoing basis and all clinical department heads were responsible for ensuring there was a system for monitoring implementation of the resident care plans. 1) Resident #2 had diagnoses including acute osteomyelitis (bone infection) of the right ankle and foot. The 6/9/2025 Minimum Data Set assessment documented the resident was cognitively intact, had intravenous access, and received intravenous medications. Physician orders documented: on 6/12/2025 change the transparent dressing and securement device every 7 days and as needed. on 7/10/2025 cefiderocal sulfate tosylate (antibiotic) intravenous solution reconstituted. Use 0.75 gram intravenously two times a day for right ankle osteomyelitis. on 7/21/2025 change peripherally inserted central catheter line intravenous tubing one time a day for routine care; change needleless connector on peripherally inserted central catheter line every 7 days; measure external catheter length from insertion site upon admission and with each dressing change; saline flush intravenous solution use 10 milliliter intravenously two times a day for routine care and 10 milliliters before and after administration. The Comprehensive Care Plan initiated 5/16/2025 documented the resident was on antibiotic therapy. Interventions included administer antibiotic as ordered, monitor for adverse reactions to antibiotic therapy, and monitor for secondary infections related to antibiotic therapy. The Comprehensive Care Plan did not include the use of a peripherally inserted central catheter or interventions for management and monitoring of the peripherally inserted central catheter. During an observation on 7/17/2025 at 12:08 PM, Resident #2 had a peripherally inserted central catheter in their left upper arm with a dressing dated 7/6/2025. During an interview on 7/22/2025 at 10:26 AM, Licensed Practical Nurse #4 stated Resident #2 had a peripherally inserted central catheter managed by the registered nurses. They were unaware it was not in the resident's care plan but thought it should be, so all staff knew it was there and how to monitor and care for it properly. They had access to care plans but thought the registered nurses, Director of Nursing, and the Assistant Director of Nursing were responsible for reviewing and updating care plans during care plan meetings. (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 7/22/2025 at 11:14 AM, Registered Nurse Manager #5 stated registered nurses initiated, reviewed, and updated care plans quarterly, when there was a change in the resident's condition. They stated they were responsible for Resident #2's care plan. Resident #2 had a peripherally inserted central catheter in their left upper arm they received medication through. They were unsure why it was not in the care plan, and it should have been added because it required ongoing assessments, care, and frequent monitoring. 2) Resident #50 had diagnoses including stroke with right side hemiplegia (paralysis) and right hemiparesis (weakness) and falls. The 6/13/2025 Minimum Data Set assessment documented the resident was cognitively intact, required partial/moderate assistance with bed mobility, toileting hygiene, showering and bathing, lower body dressing, putting on/taking off footwear, and had one fall without injury since admission or reentry. The Comprehensive Care Plan initiated 6/23/2025 documented the resident had an actual fall due to psychoactive drug use and an unwitnessed fall out of bed reaching for an item from the side stand table. Interventions included grabber tool for items out of reach, appropriate footwear when ambulating or mobilizing in wheelchair, and two bilateral floor mats. The undated resident care instructions (Kardex) documented the resident was a high risk for falls and required two bilateral floor mats. Resident #50 was observed at the following times: on 7/16/2025 at 1:58 PM, lying in bed with one gray fall mat on the left side of the bed. on 7/17/2025 at 12:23 PM, lying in bed with one gray fall mat on the left side of the bed. There was a gray fall mat standing upright between the tall dresser and the wall. The resident stated the floor mat that was standing up was not being used on the floor anymore. on 7/18/2025 at 9:07 AM and 7/21/2025 at 11:00 AM, sitting on the edge of their bed. There was a gray floor mat on the left side of the bed, and a gray fall mat standing upright between the tall dresser and the wall. During an interview on 7/22/2025 at 10:14 AM, Certified Nurse Aide #7 stated they had access to all resident care plans, and they reviewed them regularly because the care plan included everything they needed to know about a resident and how to properly care for them. They provided care to Resident #50 who was a fall risk. The resident had only one fall mat in use. They stated Resident #50 was supposed to have bilateral fall mats and the care plan should have been followed to prevent injuries if the resident had another fall out of bed. During an interview on 7/22/2025 at 10:26 AM, Licensed Practical Nurse #4 stated all nursing staff had access to care plans, and they contained everything they needed to know about a resident so they could properly care for them. Resident #50 was a fall risk and was care planned for bilateral fall mats. They were unaware the resident had one floor mat in use. The care planned should be followed because if the resident had another fall the floor mats would decrease their risk for injuries. During an interview on 7/22/2025 at 11:14 AM, Registered Nurse Manager #5 stated Resident #50 was a fall risk and was care planned for bilateral fall mats. They were unaware the resident had one fall mat in use. If Resident #50 had another fall they were at a higher risk for injuries without bilateral fall (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mats. 3) Resident #6 had diagnoses including atrial fibrillation (irregular heart rhythm). The 4/25/2025 Comprehensive Minimum Data Set assessment documented the resident had moderately impaired cognition and was on an anticoagulant (blood thinner). The 4/3/2025 physician order documented apixaban (anticoagulant) oral tablet 2.5 milligrams by mouth, two time a day for atrial fibrillation. The 6/30/2025 Comprehensive Care Plan did not include anticoagulant therapy with a focus on monitoring the effects of the medication.During an interview on 7/18/2025 at 9:45 AM, Licensed Practical Nurse #4 stated Resident #6 was on anticoagulant therapy and did not have risks of anticoagulant therapy included in their care plan and it should be included. During an interview on 7/18/2025 at 10:32 AM, Registered Nurse Unit Manager #5 stated anticoagulant therapy should be included in the care plan for any resident prescribed anticoagulants. It was important for the care plan to include risks for anticoagulant therapy so staff and knew how to appropriately provide care. Resident #6 was on anticoagulant therapy and did not have a care plan for its use. The care plan should include anticoagulant use, so staff were aware of signs and symptoms to look for related to anticoagulant therapy. Anticoagulant therapy and an associated diagnosis were missed when the care plan was created. The Director of Nursing, Assistant Director of Nursing or the Unit Manager were responsible for updating and ensuring accuracy of the care plan. Anticoagulant therapy and associated diagnosis were missed when the care plan was created. During an interview on 7/22/2025 at 12:51 PM, the Director of Nursing stated they and the Assistant Director of Nursing were responsible for creating and updating care plans. Care plans were reviewed and updated quarterly and with need. Care plans should include medications, central lines, and fall risk interventions. 10NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews during the recertification and abbreviated (NY00368679) surveys conducted 7/16/2025-7/22/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (2) of five (5) residents (Residents #17 and 31) reviewed. Specifically, Resident #17 had brown debris behind long, untrimmed fingernails and Resident #31 had long, sharp fingernails and poor oral hygiene.Findings include: The facility policy Activities of Daily Living (ADL) Care and Support, issued 6/2023, documented staff provided assistance for residents who were unable to carry out care independently as documented on the person-centered care plan and included showering, toileting, dressing, and grooming. 1) Resident #31 had diagnoses including cerebral infarction (stroke), aphasia (difficulty speaking), and hemiplegia (paralysis on one side). The 6/13/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject care, and was dependent for most activities of daily living.The Comprehensive Care Plan initiated 3/18/2006 and revised 12/15/2020, documented the resident required assistance with self-care and mobility related to cerebral infarction and hemiplegia. interventions included oral care daily with total dependence of one. The resident's undated care instructions (Kardex) documented the resident received showers on Tuesday and Friday on the day shift, received tube feedings for nutritional needs, had nothing to eat or drink by mouth, received oral care daily, and was dependent on one for oral care. Resident #31 was observed on 7/16/2025 at 1:51 PM, 7/17/2025 at 11:43 AM, 7/18/2025 at 9:43 AM, and 7/21/2025 at 11:02 AM with long sharp fingernails on the right hand, the left hand was contracted, and the fingernails could not be observed. The resident had foul smelling breath, and a white film on their teeth. The certified nurse aide activities of daily living log documented the resident received oral care twice daily on the day and evening shift. Certified Nurse Aide #11 documented completion of oral care on both the day and evening shift on 7/18/2025. During an interview on 7/16/2025 at 1:51 PM, Resident #31's family member stated they visited often and observed the resident’s mouth was dry, their breath smelled bad, and a white film was on their teeth. They stated the resident should get better oral hygiene. During an interview on 7/21/2025 at 2:39 PM, Certified Nurse Aide #11 stated they were responsible for bathing and grooming residents including nail care and oral care. They showered Resident #31 on 7/18/2025 and did not do nail or oral care. They believed nail care was only provided by licensed practical nurses for Resident #31 because their left hand was contracted, and they did not want to hurt the resident. They stated the resident often had bad breath, and they did not provide oral care for the resident because they thought the licensed practical nurse completed oral care because the resident received a tube feeding and they were worried the resident could choke. During an interview on 7/21/2025 at 10:53 AM, Certified Nurse Aide #12 stated their duties included assisting residents with showers and grooming. Resident #31 was on their assignment for the day, and all their care was provided. The resident did not refuse any care. Nail care should be completed on the resident’s shower day or with daily care when needed. They were responsible for cleaning and clipping nails unless the resident was a diabetic, then the licensed practical nurse was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible. They did not clip or clean Resident #31 nails because they did not notice they were long or had sharp edges. During an interview on 7/21/2025 at 11:02 AM, Dentist #14 stated it was important for all residents to have their teeth brushed to remove plaque and decrease the chance of dental caries and for overall health. Teeth should be brushed at least daily. They stated the resident had tarter build up, bad breath, and should have their teeth brushed. During an interview on 7/21/2025 at 1:08 PM, Licensed Practical Nurse #15 stated they expected nail care and oral care to be completed by certified nurse aides assigned to the resident. If a certified nurse aide was not able or did not feel comfortable completing nail or oral care, they should notify the licensed practical nurse who would complete the care. They stated Resident #31's nails were sharp and should be clipped, the resident had bad breath, and tarter build up on their teeth. During an interview on 7/21/2025 at 1:30 PM, Registered Nurse Unit Manager #16 stated hygiene care was completed by nursing staff which included certified nurse aides and licensed practical nurses. Residents were showered twice a week and hygiene care was completed daily. Nail care should be completed on their shower day but could be done whenever needed. Certified nurse aides completed nail care for all residents unless they were diabetic, then care was completed by the licensed practical nurse. Resident #31 drooled a lot and frequently had bad breath. It was important to provide nail and oral care for dignity and self-esteem. 2) Resident #17 had diagnoses including renal abscesses (collection of pus), osteomyelitis (bone infection), and discitis (inflammation of spinal disc). The 5/12/2025 Minimum Data Set assessment documented the resident had intact cognition and required maximum assistance or was dependent for most activities of daily living. The 1/2/2025 Comprehensive Care Plan documented the resident had a deficit in self-care function. Interventions included maximum assistance of 2 for upper body dressing, showering, and set up for eating and personal hygiene. The resident’s Kardex (care card) documented the resident’s shower days were Wednesday and Saturday on the 6:00 AM to 2:00 PM shift and required set up for personal hygiene. The following observations were made of Resident #17: on 7/16/2025 at 11:40 AM with long, yellowed fingernails on both hands. The right ring, middle finger and thumb had brownish debris under the nails. The resident stated they hated having long fingernails, but they could not get anyone to trim them. on 7/17/2025 at 11:51 AM with long fingernails and brown/black debris under all nails on both the right and left hands. on 7/18/2025 at 8:43 AM in bed with long fingernails and debris under their right pointer fingernail and the thumb, pointer, middle fingers of their left hand. on 7/21/2025 at 9:38 AM their pointer, middle and ring fingers on the right hand and middle and ring finger on their left hand had visible brown/black matter under the nails. The resident’s fingernails were long and yellowed on both hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/2025 at 10:08 AM, Certified Nurse Aide #24 stated morning care for a resident included toileting, personal hygiene, dressing, and getting them up for breakfast or an activity. Nail care occurred on a resident’s shower day or any day a resident’s nails needed to be done. They did not perform nail care on Resident #17 during the days they were scheduled to care for the resident. They noticed Resident #17’s nails were long when they provided care. They did not know why they did not do nail care. During an interview on 7/22/2025 at 10:34 AM Licensed Practical Nurse #13 stated the certified nurse aides were responsible for nail care. Nail care should be completed on shower days and as needed. A resident should not have long nails if they did not want them. Resident #17 did not refuse nail care. They saw Resident #17’s nails that morning and their nails needed care. During an interview on 7/22/2025 at 11:30 AM, Licensed Practical Nurse Unit Manager #18 stated nail care should be done after showers and as needed but after showers was best. They were unaware of why Resident #17 did not have nail care completed. If a resident had long nails with debris under them, nail care should be completed. 10 NYCRR 415.12(a)(3)

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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. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure the resident environment remained free of accident hazards for one (1) of two (2) residents (Resident #1) reviewed. Specifically, Resident #1 had a physician order to provide line-of-sight supervision for all intakes, and the resident was observed eating unsupervised in their room without staff in the vicinity. Findings include:The facility policy Dysphagia Management, revised 1/9/2023, documented residents who had dysphagia (difficulty swallowing) would be referred to Rehabilitation for evaluation and treatment interventions to promote adequate nutrition and hydration. Collaboration with the dietitian would determine the most appropriate diet based on nutrition assessment and dysphagia evaluation. An interdisciplinary patient-centered care plan for dysphagia would be developed.Resident #1 had diagnoses including right sided paralysis and weakness following a stroke, dysphagia, and acute respiratory failure with hypoxia (low oxygen levels). The 5/9/2025 Minimum Data Set documented the resident had severely impaired cognition, received a mechanically altered diet, did not have a swallowing disorder, and required set up for eating.The 5/15/2024 physician order documented a house diet with regular/whole texture, moderately thick consistency, follow dining strategies, staff to cut solids into bite sized pieces and open containers and condiments, and provide line-of-sight supervision for intake.The 6/6/2025 Comprehensive Care Plan documented the resident had an activities of daily living self-performance deficit related to confusion, functional limitations, neurological deficits due to frontal lobe deficit related to their stroke. Interventions included staff to cut solids into bite sized pieces, open containers and condiments, seat the resident in a chair or upright in bed at 90 degrees, alternate liquids and solids, alternate taking bites and sips at a slow rate, remain seated upright for 30-45 minutes after every meal, contact guard assistance of one for eating, and provide direct supervision, line-of-sight, while eating.The following observations of Resident #1 were made: on 7/17/2025 at 12:42 PM, sitting up in bed with their eyes closed. Their lunch was on the bedside table across their lap. There was no staff in the room or in line-of-sight.on 7/18/2025 at 12:48 PM, Certified Nurse Aide #23 brought Resident #1's lunch tray into their room. They set up the tray on the overbed table and left the room. There were no staff in the hallway or within line-of-sight of the resident. At 12:53 PM, Certified Nurse Aide #24 and the Activities Director entered the room with a tray for the resident's roommate and left the room. From 12:55 PM to 1:26 PM, the resident ate their meal without line-of-sight supervision. The resident coughed several times while drinking.During an interview on 7/22/2025 at 10:08 AM, Certified Nurse Aide #24 stated the meal ticket should document if a resident needed assistance while eating. If the resident's care plan documented to be eyeline supervision for eating, the resident should not be left alone with their meal. They stated they were unaware Resident #1 required line-of-sight supervision when they dropped off the resident's tray on 7/17/2025.During an interview on 7/22/2025 at 10:34, Licensed Practical Nurse #13 stated if a resident required eye-line supervision for eating they needed to be supervised so they did not aspirate (inhale food/drink into lungs) while eating or drinking. They assisted with serving trays on the unit and was unaware Resident #1 required eyeline supervision for their meals. The resident should not be left alone in their room with their meal tray as it was not safe, and the resident could aspirate. They stated there was not enough staff to supervise the resident while they ate in their room.During an interview on 7/22/2025 at 11:30 AM, Licensed Practical Nurse Unit Manager #18 stated if a resident was eyeline supervision for eating they had to be in sight of staff during the meal. Resident #1 should not be left alone to eat in their room if they required line-of-sight supervision. They stated there was not enough staff to watch the resident in their room if they did not want to get up for lunch. There was no excuse not to watch the resident, but it was between not feeding the resident if they did not want to get up or giving the resident their tray and not supervising them.During an interview on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/22/2025 at 1:08 PM, Nurse Practitioner #26 stated that if a resident's orders documented the resident should be within eyeline supervision during meals they expected staff to supervise the resident. It was important to supervise the resident for aspiration precautions or choking precautions. If a resident was not supervised staff could not intervene timely if they choked. They stated they were unaware Resident #1 was eyeline supervision and was not supervised during meals. 10 NYCRR 415.12(h)(1)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for one (1) of four (4) residents (Resident #39) reviewed. Specifically, Resident #39 had weight loss not addressed by the physician or dietitian and there was no documented verification of the resident's actual weight. Findings include:The facility policy Clinical Services: Weight Policy and Procedure, revised 10/2023, documented residents were to have monthly weights obtained and recorded. Significant weight changes would have a verification of weight measurement for accuracy and documentation purposes. If verification indicated significant weight change the resident, the resident's family/representative, and the dietitian would be notified and the plan of care revised. Resident #39 had diagnoses including adjustment disorder and emphysema (progressive lung disease). The 6/26/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, required substantial assistance or was dependent for all activities of daily living, weighed 113 pounds, and did not have weight loss. The Comprehensive Care Plan updated 11/13/2024 documented the resident had a nutrition diagnosis of unintended weight loss related to varied oral intake. Interventions included, monitor/evaluate weight/weight changes, monitor/record/report to physician significant weight loss, notify registered dietitian, family, and physician of significant weight changes. Physician orders documented: 8/3/2024 8 ounces Mighty Shake (nutritional supplement) 10/24/2024 weekly weights every Friday 11/13/2024 8 ounces Ensure Plus (nutritional supplement) two times a day to promote weight maintenance/adequate oral intake 3/25/2025 house diet, regular texture and thin consistency. The resident's record documented the following weights: on 5/30/2025 113 pounds on 6/2/2025 113 pounds on 6/20/2025 112.5 pounds on 7/7/2025 99 pounds (12.39 % loss x 30 days). There was no documented evidence a re-weight was obtained after significant weight loss. There was no documented evidence the family, physician, or dietitian were notified timely of the significant change in weight. During an observation on 7/17/2025 at 12:35 PM Resident #39 was assisted with eating and consumed less than 50% of their lunch meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/18/2025 at 8:37 AM Resident #39 was sitting at a dining room table being encouraged to eat but was not physically assisted. The 7/18/2025 at 1:41 PM Registered Dietitian #21 progress note documented they reviewed the resident's weights and noted a severe decline over the past month. The resident's original weight was 99 pounds on 7/7/2025 and a reweight was obtained as requested today 7/18 of 107.5 pounds (11 days after the original weight of 99 pounds). The recommendation included routine weights be done consistently in the resident's wheelchair versus standing and initiating weekly weeks. The resident's appetite remained variable at 50-100% intake at meals. During an interview on 7/18/2025 at 11:11 AM, Certified Nurse Aide #7 stated after they weighed the resident, they documented the weight in the electronic record. The weight popped up red if the resident lost weight and they would tell the nurse. They were Resident #39's aide on 7/7/2025, but they did not weight the resident. They stated a different aide weighed the resident for them that day. If they had gotten that weight, they would have told the nurse. During an interview on 7/18/2025 at 12:42 PM, Certified Nurse Aide #27 stated when they weighed a resident and the weight was low, they re-weighed the resident either the same day or the next day. They would let the nurse know the resident lost weight. They weighed Resident #39 on 7/7/2025. They looked at the old weight for the resident prior to inputting the new weight. They informed Licensed Practical Nurse #28 about the weight loss and was told that since the resident had not been eating well and was having a lot of lose stool, weight loss was expected. During an interview on 7/18/2025 at 1:27 PM, Licensed Practical Nurse #28 stated if there was a big discrepancy in weights they expected to be notified by the aides. Every nurse should check their assigned resident's weights, even if they were not told by the aides. If they noticed a big weight difference they should weigh the resident again, let the provider know, and document in the electronic record the provider was notified. Resident #39 lost weight as they were not eating a lot and had loose stools last month. They were not sure why there was not documentation a provider was notified or if the resident was reweighed. During an interview on 7/21/2025, Registered Nurse Unit Manager #5 stated last month there were a lot of residents with stomach issues with vomiting and diarrhea and they expected some weight loss to happen. The medical provider, family, and the dietitian should be notified of weight loss even if it was expected. They stated they were sure the weight loss from 7/7/2025 was reported to the provider. During an interview on 7/22/25 at 12:51 PM, Registered Dietitian #21 stated they should be notified if a resident lost 5% of their weight in 1 month or 10% of their weight in 6 months. They started running weight reports. When weight loss was noticed the resident should be reweighed to confirm accuracy. Resident #39 was experiencing weight loss, and they were following. They noticed the weight from 7/7/2025 and asked for a re-weight. They were not sure why they did not document the follow-up in the electronic record. 10NYCRR 415.12(i)1

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations and interviews during the recertification survey conducted 7/16/2025-7/22/2025, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for two (2) of three (3) medication carts (2nd floor low end medication cart and the 4th floor low end medication cart) and one (1) of two (2) medication rooms (2nd floor medication room) reviewed. Specifically, the 2nd floor low end medication cart had one expired inhaler and one opened and undated insulin pen; the 2nd floor medication room had one opened, undated bottle of liquid gabapentin (seizure medication); and the 4th floor low end medication cart had one bottle of expired multidose eye drops and one open and undated insulin pen.Findings include:The undated facility policy Medication Storage, documented prior to and after opening, all medications would expire on the date specified by the manufacturer on the product label, unless the manufacturer had specifically indicated a shortened expiration once opened on the product label itself. The policy did not include instructions for labeling multidose vials or discarding expired medications. During an observation on 7/16/2025 at 12:02 PM, the 2nd floor low end medication cart contained one opened and undated Lispro insulin pen and one ipratropium and albuterol inhaler dated as opened on 5/6/2025.During an observation on 7/16/2025 at 12:19 PM, the 2nd floor medication storage refrigerator contained one open and undated bottle of liquid gabapentin (seizure medication).During an interview on 7/16/2025 at 12:26 PM, Licensed Practical Nurse #8 stated all nurses were responsible for checking the medication carts and refrigerators for expired items and ensuring all items were dated. If medications were not dated or past their expiration date they should be discarded. Inhalers and insulin should be discarded after 30 days as the efficacy of the medications diminished. They stated they were unsure why the open undated medications were still in the medication cart or medication refrigerator.During an observation on 7/16/2025 at 12:42 PM, the 4th floor low end medication cart contained one opened bottle of eye drops dated 6/13/2025 and one opened and undated Basaglar insulin pen.During a telephone interview on 7/22/2025 at 11:30 AM, Licensed Practical Nurse #17 stated all nurses should check the medication cart for expired medications and checking to ensure all items were dated when opened. Insulin pens and eye drops were good for 30 days once opened. All medications should be dated when opened. If a medication was expired or not dated, it should be discarded. They stated they were unsure why those medications were still in the medication cart.During an interview on 7/22/2025 at 1:30 PM, Licensed Practical Nurse Unit Manager #18 stated all nurses should check the medication carts to ensure all medications were labeled and were not expired. If the items were unlabeled or expired, they should be discarded and not used.10NYCRR 415.18(d)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025 - 7/22/2025, the facility did not ensure each resident received food that accommodated resident allergies, intolerances, and preferences for four (4) of four (4) residents (Residents #20, #57, #100, and #112) reviewed. Specifically, Residents #20, #57, #100, and #112 did not receive items documented on their meal tickets.Findings include:There was no documented facility policy regarding accuracy of meal trays. 1) Resident #20 had diagnoses including multiple myeloma (blood cancer). The 4/29/2025 Minimum Data Set assessment documented resident had moderately impaired cognition and required set up assistance for eating. The 11/20/2024 Comprehensive Care Plan documented the resident had nutritional problems related to a diagnosis of multiple myeloma and was receiving chemotherapy. Interventions included house diet, encourage fluids, encourage food related activities, monitor for weight loss, and evaluate food and beverage intakes. The 4/16/2025 Registered Dietitian #20 progress note documented Resident #20 had a nutritional goal of adequate oral/fluid intake to promote weight gain/maintenance, prevent skin breakdown, and promote a normal body mass index. The resident continued a regular diet with fortified cereal at breakfast, fortified pudding at lunch, and Ensure and 2 Cal HN (liquid nutritional supplements) daily for additional calories and protein to promote weight gain. During an observation on 7/16/2025 at 12:18 PM, the resident's lunch meal ticket documented a dinner roll and 2% milk. The lunch tray did not include either item. During an observation and interview on 7/17/2025 at 12:20 PM, the resident's meal ticket documented cornbread, fortified chocolate pudding, and 2% milk. The lunch tray did not include these items. The resident stated they wanted the cornbread and the pudding and would eat it if they had it. During an observation on 7/17/2025 at 12:22 Certified Nurse Aide #2 asked Resident #20 if they wanted their missing cornbread and milk. The resident stated they wanted the cornbread but did not want the milk. They were not asked about the fortified chocolate pudding. Certified Nurse Aide #2 gave the resident a piece of cornbread which the resident consumed. 2) Resident #57 had diagnoses including dementia, abnormal weight loss, and moderate protein-calorie malnutrition. The 4/22/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and required set-up assistance for eating.The 4/9/2025 Comprehensive Care Plan documented the resident was at risk for malnutrition related to dementia. Interventions included encourage favorite foods, monitor food/fluid intake, monitor weights, provide 60 milliliters of 2 Cal HN (nutritional supplement) four times a day, Mighty Shake (nutritional supplement) at bedtime, and honor food preferences. The 5/29/2025 Registered Dietitian #21 progress note documented Resident #57 had several interventions along with weekly weights in place for low body mass index and weight loss. The resident had a weight decline over the last six months. Interventions in place included fortified cereal at breakfast, sandwich at lunch and dinner, 60 milliliters of 2 Cal HN four times a day, and Mighty Shake at bedtime. During an observation and interview on 7/16/2025 at 12:20 PM, the resident's lunch meal ticket documented a peanut butter and jelly sandwich. The lunch tray was missing the peanut butter and jelly sandwich and the resident stated they would eat it if they had it.3) Resident #112 had diagnoses including end stage renal (kidney) disease and severe protein calorie malnutrition. The 6/18/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and required set-up assistance for eating. The 2/13/2025 Comprehensive Care Plan documented the resident was malnourished related to a new diagnosis of renal dialysis (filtering of blood). Interventions included allow sufficient time to eat, monitor food/fluid intake, monitor weighs, and honor food preferences. The 6/5/2025 Registered Dietitian #22 progress note documented Resident #112's body mass index was 16.8 which was underweight related to end stage renal disease and increased nutritional needs. The resident was to continue double portions of entree, starch, cereal, and beverage. During an interview on 7/17/2025 at 11:15 AM, Resident #112 stated they attended (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis Monday, Wednesday, and Friday at 5:00 AM. Prior to leaving for dialysis the nurse made them toast, one cereal, and cranberry juice. They returned to the facility at approximately 10:45 AM in time for lunch. They were losing weight and trying to gain weight back by eating more. During an observation and interview on 7/18/2025 at 12:32 PM, the resident's lunch meal ticket documented one pound of meat sauce with spaghetti noodles. The meal tray had a single portion of spaghetti and meat sauce. The resident stated they were still hungry. They stated they never received double portions and would love them, especially when they had eggs. They often asked for seconds of the main entree and if there was enough leftover they received them. If there was not enough leftover, they did not receive the second helping. They stated they would prefer not having to ask for the second helping. The resident ate all the first helping of meat sauce with spaghetti and 75% of the second serving of meat sauce with spaghetti. During an interview on 7/21/2025 at 9:32 AM, Certified Nurse Aide #2 stated the kitchen staff was responsible for making sure all items listed on the meal ticket were on the resident trays. The food service aide working the floor was the second check and staff who delivered the tray to the resident was the third check to make sure trays were accurate. Items were often missing from trays. Last week Resident #20 was missing cornbread, and they asked the food service aide for a piece of cornbread. They did not realize the resident was missing their fortified pudding. Resident #57 was trending for weight loss and often did not eat the main entree but usually ate the peanut butter and jelly sandwich in addition to their main entree. It was important for them to get the sandwich and without it they might not get the protein and calories they needed. There were two residents on double portions. Double portions were documented on the meal ticket as double portions and highlighted in yellow. Resident #112 was not on double portions and the ticket did not document double portions. The resident often asked for seconds and received them when available. During an interview on 7/21/2025 at 9:58 AM, Food Service Aide #3 stated they were responsible for serving residents meals. They prepared resident trays with cups, silverware, and condiments prior to the mobile serving steam cart arriving on the unit. There were times residents did not get items listed on the tickets because the Food Service Director did not order enough. They stated there were no dinner rolls available for the 7/16/2025 lunch meal, they ran out of cornbread on 7/17/2025, and no substitutions were made for the missing items. There was no fortified pudding on 7/17/2025 for Resident #20 and it was important for resident to get all the listed items to prevent weight loss. They had two residents that received double portions, but double portions were not documented anywhere on the meal ticket. Resident #112 was not on double portions but often asked for seconds. During an interview on 7/21/2025 at 1:08 PM, Licensed Practical Nurse #15 stated anyone who passed a meal tray was responsible for making sure all items documented on the tickets were on the tray. They noticed trays missing items and notified the food service aide. There were times items listed on the tickets were not available. Residents who lost weight might have fortified puddings, protein supplements, or preferred substitutions. Resident #57 often did not eat their main entree but usually ate their peanut butter and jelly sandwich. Resident #57 was losing weight, and it was important for them to get their sandwich. They were not sure why it was not on the tray. Double portions were usually ordered because a resident required additional calories or protein, and it was documented on their meal ticket. During an interview on 7/21/2025 at 1:30 PM, Registered Nurse Unit Manager #16 stated there were times items were missing from resident meal trays. They notified the food service aide who gave them the missing item. At times they ran out of an item and a substitution was made. Resident #57 always got a peanut butter and jelly sandwich with lunch and dinner because they often refused the main entree and would eat the sandwich. Residents should get double portions at the request of the dietitian and if ordered they should get them. They were unsure if Resident #112 received double portions. During an interview on 7/22/2025 at 7:31 AM, Registered Dietitian #21 stated when a resident was at risk for malnutrition or weight loss, they usually recommended supplements, and they entered the recommendation into the computer. They worked closely with families and the Food Service Director. When a recommendation was made, they added it to the care (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335374	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan and expected it to be carried out. They recommended double portions for residents who had increased healing or protein needs. Fortified pudding was recommended for Resident #20, and they expected the resident to get the item. Resident #112 had weight loss and double portions were recommended. Double portions was listed on their ticket as x 2 next to the entree. Double portion was not documented anywhere on the meal ticket. They were not sure if staff knew the meal tickets did not say double portions or where to look when a resident required double portions. Resident #57 was being monitored for weight loss, and they preferred a peanut butter and jelly sandwich which was listed on all lunch and dinner meal tickets, and they expected it to be on the resident's tray. During an interview on 7/22/2025 at 9:18 AM, the Food Service Director stated the food service aide was responsible for making sure trays were accurate and all items on the ticket were on the tray. If an item was missing, they should call the kitchen. Last week dinner rolls were accidently not put on the third-floor cart. Food Service Aide #3 never called the kitchen to notify them the item was missing and did not ask for a replacement. When an item was missing the Food Service Director expected staff to call and notify them. Cornbread was part of the meal and Food Service Aide #3 should have called the Food Service Director. They stated Resident #112 was on double portions. Resident #57 should always get their peanut butter and jelly sandwich as they were losing weight, and it was their preference. 10NYCRR 415.14(d)(3)(4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey conducted 7/16/2025 - 7/22/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for one (1) of one (1) main kitchen. Specifically, in the main kitchen the preparation sink was leaking with a puddle underneath; the walk-in cooler had a black substance on the back wall, the cooler contained personal items, undated and/or uncovered food, and expired food; the walk-in freezer had uncovered food items; and the dry food storage area had dented cans. Additionally, the 3rd floor kitchenette had outdated bread. Findings include:The facility policy Storage of Food & Supplies, revised 2/2022, documented food and food supplies were stored to minimize exposure to splash, dust, or other contamination. Food products that were opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored would be labeled as to its contents and used by dates. Discard food that is damaged.The facility policy Sanitation of Kitchen, Food Service Equipment & Work Surfaces, revised 2/2022 documented the frequency of cleaning foodservice equipment and surfaces that were nonfood-contact surfaces was dependent on the type of equipment and was outlined on the cleaning schedules.The July 2025 Daily Kitchen Cleaning log documented to wash the inside and outside of the refrigerator.The following observations were made in the main kitchen on 7/16/2025 between 10:08 AM and 10:42 AM:the walk-in cooler shelf contained 1 soft side employee lunch box and a 16-ounce soft drink. There were 16 uncovered four-ounce plastic dishes of pudding; a 2.5 quart of chicken noodle soup dated 7/9/2025; five pounds of undated deli turkey wrapped in plastic; 4 pounds of undated cooked pasta in a metal pan; an undated 1.5 pound plastic container of diced cooked potatoes; an undated plastic quart of sliced black olives; a plastic container of sliced oranges dated 7/2/2025 with a use by date of 7/5/2025; and 2 uncovered and undated metal pans of gelatin.the walk-in freezer contained one 12-pound cardboard box of stuffed shells, and one cardboard box of breakfast pastries open to air.the dry storage area contained one dented 4-pound can of tuna dated 6/10/2025 and one dented 7-pound can of cranberry sauce.the kitchen preparation sink was leaking from the drain with a puddle approximately 3 feet by 2 feet. A juice nozzle was on the floor approximately 4-inches from the pooling water.The following observations were made in the main kitchen on 7/17/2025 between 8:28 AM - 8:48 AM:the walk-in cooler contained 1.5 pounds of undated American cheese wrapped in plastic and 1.5 pounds of undated Swiss cheese wrapped in plastic. Additionally, the walls in the back of the walk-in cooler next to the freezer door had a black substance on the white paneling. The right-side wall had a black substance extending 24 inches in length from the floor and 6-8 inches in width. The left side had a black substance extending from the ceiling to the floor that was 6-8 inches wide.the kitchen prep sink was leaking with a 6-inch by 8-inch puddle on the floor.During an interview on 7/17/2025 at 8:52 AM, the Food Service Director stated food items should be used by the best used by date/expiration on the original package and if the food item was placed in another container, it should be used with 3 days of the item being opened to ensure food did not expire and was good quality. All food should be covered to prevent physical contamination. All staff should be checking the can goods to ensure they were not dented. Dented cans should be discarded as they posed a food safety risk. The walk-in cooler and freezers should be swept and cleaned daily. The walls should be cleaned monthly and as needed to prevent the buildup of debris. The juice nozzle should not be on the floor as it was not sanitary, and the maintenance department was made aware of the leaking sink. The equipment in the kitchen, such as the sink, should be in good repair for safety reason and was important for pest control issues as pooling water could attract pests.The following observations were made in the 3rd floor kitchenette:on 7/18/2025 at 8:33 AM there was 1 loaf of bread dated 5/22/2025.on 7/21/2025 at 9:31 AM, there was 1/4 loaf of bread dated 5/21/2025.During an interview on 7/21/2025 at 9:32 AM, Certified Nurse Aide #2 stated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the loaf of bread should be discarded as it was past the best used by date. The food service staff was responsible to stock the items on the unit and remove any outdated items. During an interview on 7/21/2025 at 9:58 AM, Foodservice Aide #3 stated they made toast with the bread on the unit that morning at breakfast. They were responsible for checking the dates on the food items and discarding any items that were past their used by date. They were unaware the bread had a used by date on it.There was no documented work order for the leaking kitchen prep sink.NYCRR10 415.14(h)