STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335375	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schuyler Hospital Inc & Long Term Care Unit	220 Steuben Street Montour Falls, NY 14865

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews and record review conducted during the Recertification Survey for two (Residents #5 and #59) of four residents reviewed, the facility did not ensure the residents were treated with respect and dignity and care for the resident in a manner and environment that promotes enhancement of their quality of life. Specifically, staff did not provide the resident privacy during the medication administration of injections. This is evidenced by the following: 1. Resident #59 was admitted to the facility with diagnoses that included diabetes, obesity, and lymphedema (tissue swelling in the arms or legs). The Minimum Data Set Resident assessment dated [DATE] revealed Resident #59 was moderately impaired cognitively and received daily insulin injections. Review of the resident's Comprehensive Care Plan revealed that Resident #59 was dependent on staff for locomotion in their wheelchair while on the unit. During an observation on 3/26/24 at 12:15 PM, Resident #59 was sitting in their wheelchair in the dining room awaiting lunch with two other residents at their table. Registered Nurse #1 approached Resident #59 who proceeded to lift the bottom of their shirt, exposing their abdomen and Registered Nurse #1 administered an injection into the resident's bared abdomen. At the time, seven additional residents were in the dining room. 2. Resident #5 was admitted to the facility with diagnoses that included diabetes, dementia, and gastritis (inflammation of lining of the stomach). Review of the Minimum Data Set Resident assessment dated [DATE] revealed Resident #5 was cognitively impaired and received daily insulin injections. During an observation on 3/26/24 at 12:35 PM, Resident #5 was wheeled out of the dining room into the unit's hallway/common area by Licensed Practical Nurse #1. Licensed Practical Nurse #1 proceeded to administer an injection into what appeared to be Resident #5's abdomen while sitting in the hallway/common area where other residents were sitting. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/24 at 3:08 PM, Registered Nurse #1 said when administering medications, the general rule is to give them to residents in their rooms, including injections but that occasionally they are given to residents when they are in the dining room. Registered Nurse #1 said they had given Resident #59 the injection earlier and that Resident #59 lifts their shirt for the nurses to give the injection in their abdomen, which was common practice. Registered Nurse #1 said it was difficult to push Resident #5 back to their room due to their size. Registered Nurse #1 said there were other residents in the dining room at the time and some may not have been able to voice any concerns related to observing the resident's abdomen or an injection being administered. During an interview on 3/26/24 at 3:15 PM, Registered Nurse Manager #3 said injections should be administered to residents behind a door or curtain to provide dignity and privacy. Registered Nurse Manager #3 said the unit's hallway/common area, or the dining room were not appropriate places to give injections. Registered Nurse Manager #3 said there were residents on the unit that would not have been able to communicate if the observations bothered them. During an interview on 3/28/24 at 1:07 PM, the Director of Nursing said blood glucose checks and injections are not to be given in public areas but instead, residents should be taken to a secluded area where other residents could not see them. The Director of Nursing said the dining room or hallway/common area were not appropriate places to give injections. 415.3(d)(1)(i)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on record review and interview conducted during the Recertification Survey, it was determined that for two of seven newly hired employees the facility did not implement written policies and procedures to prevent abuse, neglect, exploitation, and misappropriation of resident property related to screening prospective employees. Specifically, a nurse aide registry abuse screening was not completed for newly hired employees prior to starting work. The findings are: A review of the [NAME] Hospital Policy & Procedure for Resident Abuse, effective date February 1992 and last revised August 2017, included screening procedures that all staff will have a verification completed prior to hire through the New York State Nurse Aide Registry Verification (Prometric Report). On 3/26/24 beginning at 1:05 PM, seven newly hired employee files were reviewed and included the following: A Resident Assistant was hired on 2/19/24 and a nurse aide registry screen for prior abuse findings was not submitted until 3/26/24. A Dietary Aide was hired on 3/23/24 and a nurse aide registry screen for prior abuse findings was not submitted until 3/26/24. During an interview at this time, the Human Resources Generalist was asked by the surveyor why there had been a delay in submitting the nurse aide registry check. The Human Resource Generalist stated that the Onboarding Department completes the whole new hire process, and that the Onboarding Specialist thought they only had to run the Certified Nursing Assistants through the nurse aide registry. 10NYCRR: 415.4(b)

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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. 47642 Based on interviews and record reviews conducted during the Recertification Survey for one (Resident #27) of two residents reviewed for positioning and mobility, the facility did not ensure that the resident's person-centered care plan was implemented to ensure the resident's goals and outcomes were met. Specifically, Resident #27 was not provided a hand roll to their left-hand contracture (permanent tightening of the muscles, tendons and skin causing a decrease in range of motion and often painful) on multiple observations per physician orders, therapy recommendations and the resident's care plan. This is evidenced by the following: Resident #27 had diagnoses including Alzheimer's disease, anxiety, and contractures. The Minimum Data Set Resident Assessment, dated 1/5/24, included that the resident had severely impaired cognition, was totally dependent on staff for care and had limitations in range of motion to both upper extremities (including both hands) that interfered with daily functions. Review of current Physician orders revealed an order initiated 10/17/22 for a hand roll (soft cloth rolled up and placed in palm of hand) to left hand at all times and to remove for meals and for care every shift. Review of Resident #27's Comprehensive Care Plan revealed that the resident had contractures of both hands as identified by a rehabilitation assessment but did not include the use of hand rolls. Review of Resident #27's Kardex (care plan used by the Certified Nursing Assistants for daily care) revealed under Dressing/Splint Care: hand rolls to the left hand at all times, remove for meals and care and to monitor for any signs or symptoms of contractures forming or worsening. During an observation on 3/24/23 at 11:20 AM Resident #27 was sitting in a recliner chair in the common area. There was no hand roll in the resident's left hand. During an observation on 3/26/24 at 1:25 PM Resident #27 was transferred back to bed after lunch with the assist of two staff. No hand roll was placed in the resident's left hand. During an observation on 3/27/24 at 3:43 PM Resident #27 was resting in bed. There was no hand roll in their left hand. In an interview on 3/28/24 at 9:48 AM the Occupational Therapist stated that Resident #27 had an assessment on 1/4/24 and recommendations at that time were to continue to apply the hand roll in the left hand at all times except for hygiene and eating. In an interview on 3/27/24 at 3:58 PM Certified Nursing Assistant #2 stated that Resident #27 has contractures to both hands and that the roll should be their hand all the time. In an interview on 3/28/24 at 12:13 PM Certified Nursing Assistant #3 stated that they had taken care of Resident #27 several days this week and that they were sorry they did not put the hand roll in the resident's left hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/28/24 at 11:43 AM Nurse Manager #2 stated that staff should follow the resident's care plan and did not know why the hand rolls were not being used. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews and record review conducted during the Recertification Survey, for one (Resident #5) of one resident reviewed for insulin administration, the facility did not ensure that the services and care provided met professional standards of quality. Specifically, several nurses did not clarify a contradictory physician order regarding insulin injections, when to give and when not to give as it relates to Resident #5's meal intakes. This is evidenced by the following: The facility policy, Medication Administration - General Guidelines, dated January 2018, included that medications were to be administered in accordance with the written orders of the attending physician. Additionally, if a medication order was not clear, or questionable in any way, the nurse should contact the provider for clarification. Resident #5 had diagnoses that included diabetes, dementia, and gastritis (inflammation of lining of the stomach). Review of the Minimum Data Set Resident assessment dated [DATE] revealed Resident #5 was cognitively impaired and received insulin injections. In a nursing progress note dated 3/13/24 Licensed Practical Nurse #3 documented that Resident #5 did not eat any supper except for Ensure (nutritional supplement drink) and orange juice and that their blood glucose (sugar) level prior to supper was 59 (normal values approximately 80-120). Licensed Practical Nurse #3 documented that no insulin sliding scale coverage was given per orders from the On-Call Medical Provider Review of a physician's (telephone) order dated 3/13/24 revealed Regular insulin sliding scale (insulin dose based on resident's blood glucose level) subcutaneously (injection of medication beneath the skin) before meals and at bedtime for diabetes. Additionally, the order included to not give insulin if Resident #5 did not eat their meal. Review of the March 2024 Medication Administration Record and the Nutrition-Amount Eaten Report revealed that 44 doses of insulin were administered to Resident #5 from 3/13/24 to 3/27/24 when the amount eaten at meals was documented as refused all meal (for all three meals a day with the exception of two meals in the 15 days reviewed). During an observation on 3/26/24 at 12:38 PM, Licensed Practical Nurse #1 administered Resident #5's insulin injection before lunch. Resident #5 was then brought into the dining room and their lunch tray set up by staff. At 1:15 PM Resident #5's lunch tray was removed from the table by facility staff. All solid foods remained on the tray (not consumed by the resident) and only the Ensure drink and cranberry juice had been consumed. During an observation on 3/26/24 at 5:59 PM, Resident #5 was in bed with their dinner tray in front of them. The Ensure drink and cranberry juice had been consumed but all solid food remained untouched. Review of the 3/26/24 Medication Administration Audit Report revealed Resident #5 had received an insulin injection prior to both lunch and dinner meals despite not eating any of their meals with the exception of Ensure and juice. (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 3/27/24 at 11:00 AM, Licensed Practical Nurse #1 stated Resident #5 had blood glucose checks four times a day and should not receive insulin if their blood glucose was less than 100. Licensed Practical Nurse #1 said Resident #5's food intake was terrible, but that they would drink the Ensure. When the current physician order for insulin was reviewed at that time, Licensed Practical Nurse #1 said they were not aware the instructions to 'not give coverage if the resident did not eat' was there. Licensed Practical Nurse #1 said Resident #5 had not been eating food for a long time, but with that order, they should encourage the resident to eat. Licensed Practical Nurse #1 said the order was contradictory, (to give insulin before meals and do not give if resident did not eat). Additionally, Licensed Practical Nurse #1 said their view of the electronic Medication Administration Record did not include the additional instructions to not give the insulin if the resident did not eat. Review of the electronic medical record with the surveyor at this time, revealed that the nurses view of the medication administration record did not include to hold the insulin if the resident did not eat their meal. During an interview on 3/27/24 at 11:19 AM, Registered Nurse Manager #3 said Resident #5's orders changed when the resident had an episode of a low blood glucose level due to not eating. Registered Nurse Manager #3 said the nurses should read through the entire insulin orders to see if there were any additional instructions at the bottom. Registered Nurse Manager #3 said Resident #5 had been receiving insulin but had not been eating (solid foods) but felt that the Ensure would qualify as meal. Registered Nurse Manager #3 said they were unsure of medical provider's intent for the order (give insulin before meals and to not give insulin coverage if not eating) but would clarify it. During an interview on 3/27/24 at 11:42 AM, Nurse Practitioner #1 said insulin doses (via a sliding scale) should be given based on the blood glucose value and insulin coverage is typically given before meals. Nurse Practitioner #1 said the nurses should have clarified the insulin sliding scale order (give before meals and do not give if resident not eating) with the medical provider. During an interview on 3/28/24 at 12:07 PM, the Director of Nursing said the nurses should have clarified the insulin sliding scale order with a medical provider, since it said to give before meals and to not give if resident did not eat. The Director of Nursing said Resident #5 does not eat (solid foods) but that their weight has maintained with Ensure. 10 NYCRR 415.11(c)(3)(i)

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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. 49368 Based on observations, interviews, and record reviews conducted during a Recertification Survey, for one (Resident #50) of five residents reviewed, the facility did not ensure that a resident who is unable to carry out Activities of Daily Living received the necessary services to maintain good oral hygiene. Specifically, Resident #50 who is dependent on staff for assistance with oral hygiene was observed on several occasions with poor oral hygiene. Additionally, interviews with staff revealed that oral hygiene had not been completed despite documentation that it had been. This is evidenced by the following: Resident #50 had diagnoses including traumatic brain injury (injury to the brain caused by an external force), left sided hemiparesis (weakness on one side of the body), and seizure disorder (temporary disruption of normal brain function caused by abnormal electrical discharges in the brain). The Minimum Data Set Resident Assessment, dated 12/15/23, revealed Resident #50 had severely impaired cognition, had no behavioral symptoms, including that rejections of care had not been exhibited, and that the resident was dependent (on staff) for oral hygiene. Review of Resident #50's Comprehensive Care Plan, dated revised 3/5/24, revealed the resident had the potential for oral problems related to poor oral hygiene. Interventions included oral care twice daily and as needed. Review of Resident #50's Kardex (care plan used by the Certified Nursing Assistants for daily care) located in the resident's room revealed the resident was dependent for oral care. The Kardex did not include instructions to staff on how often or when to provide the oral care. Review of Resident #50's current Physician's orders included oral care to be completed twice daily. Review of Resident #50's most current dental note dated 9/2/23, revealed Resident #50 had gingival inflammation and heavy generalized plaque. Review of a Physician's progress note dated 3/12/24, revealed that Resident #50 was able to answer questions using a thumbs up (for yes) or thumbs down (for no) with their right thumb. In an observation on 3/24/24 at approximately 10:47 AM, Resident #50 was sitting in the dining room. Their lower teeth had large amounts of thick yellow plaque over all visible teeth. In an observation and interview on 3/26/24 at approximately 11:51 AM, Resident #50 was awake and dressed. All lower teeth were visible with a large amount of thick yellow plaque buildup. When interviewed at the time, Resident #50 indicated by putting their thumb down that staff had not brushed their teeth that morning and when asked if they wanted their teeth brushed Resident #50 demonstrated a thumbs up. Review of Resident #50's Treatment Administration Record (documentation by licensed nurses) 3/1/24-3/27/24 revealed that Resident #50's oral care was scheduled twice daily with morning care and at hour of sleep. All (with the exception of one day) had been signed off (by the nurses) as completed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #50's Certified Nursing Assistants oral care documentation (in the electronic medical record) 3/1/24-3/27/24 revealed oral care was documented as completed twice daily. During an interview on 3/27/24 at 10:26 AM, Certified Nursing Assistant #2 stated that brushing teeth should be included with morning care and overnight staff were assigned to do it for Resident #50. Certified Nursing Assistant #2 stated the resident was totally dependent (on staff), and that the overnight staff do not always do what they are supposed to do. During an interview on 3/28/24 at 11:06 AM and again at 1:34 PM, Registered Nurse Manager #1 stated that brushing resident's teeth was part of morning and bedtime care. Nurse Manager #1 stated the night shift gets Resident #50 up and the evening shift puts the resident back to bed and that the Certified Nursing Assistants on these shifts knew it was their responsibility. Registered Nurse Manager #1 said that oral care was also documented on the Treatment Administration Record for the nurses (licensed) to sign off that it had been completed. Registered Nurse Manger #1 stated that the oral care should be on the resident's Kardex but when reviewed with the surveyor, Registered Nurse Manger #1 stated that when to do the oral care was not listed. Registered Nurse Manager #1 stated if staff are signing that the oral care had been completed without knowing if it was, it was falsifying records and thinks that the nursing staff were assuming the oral care had been completed for Resident #50 when it had not. During an interview on 3/28/24 at 12:05 PM, Resident #50's representative stated that they have noticed oral care not being completed when they visit twice weekly and they try and do it. During an interview on 3/28/24 at 12:07 PM, Director of Nursing stated oral care should be completed as ordered and at minimum daily if the resident allows. 10 NYCRR 415.12(a)(3)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 46526 Based on observations, interviews, and record reviews conducted during a Recertification Survey, the facility did not ensure the nurse staffing information was posted daily and included the required information. Specifically, the nurse staffing information did not consistently include the total number and actual hours worked by licensed and unlicensed nursing staff who were directly responsible for resident care, the current resident census (the number of residents currently residing in the facility) and was not posted on a daily basis at the beginning of each shift to include any staffing changes as per the regulations. This is evidenced by the following: During an observation on 3/24/24 at 1:24 PM, the facility's nurse staffing information posted was dated 3/23/24 and did not include the current resident census. There was no information posted throughout the day for 3/24/24. During an observation on 3/25/24 at 10:56 AM, the current nurse staffing information posted did not include the resident census. Review of the nurse staffing information form titled Nursing Staffing Daily Reporting Tool from 2/26/24 to 3/26/24 revealed multiple days that did not include the total number of actual hours worked by each discipline or the resident census. During an interview on 3/28/24 at 9:58 AM, Administrative Assistant #1 said the night supervisor completed and then posted the nurse staffing information before leaving in the morning and the unit nurse managers kept track of the nursing staffing levels during the day. During an interview on 3/28/24 at 10:05 AM, Nursing Coordinator #1 said the night supervisor was responsible for posting the nurse staffing information. Nursing Coordinator #1 said when staff called off for their shift it would be updated in the scheduling book and that they did not know who would update the posting (if required). Nursing Coordinator #1 said they were not aware that the current resident census was required. During an interview on 3/28/24 at 12:07 PM, the Director of Nursing said the night shift supervisor was responsible for completing and posting the nurse staffing information and should include the date, the current resident census, the number of nurses per discipline, and the number of hours worked by each discipline. The Director of Nursing said no one was updating the postings during the day when there were staffing changes but that it should be. 10 NYCRR 415.13

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47642 Based on interviews and record reviews conducted during the Recertification Survey, for five (Resident #15, #23, #48, #59 & #64) of five residents reviewed the facility did not ensure that the influenza and/or pneumococcal immunizations were offered and provided if appropriate or that education was provided to the residents or the resident representative if appropriate. Specifically, there was no documented evidence that Resident #64 (who was eligible) or their representative had been offered, provided, declined, and/or educated on the pneumococcal immunization or had received it prior to admission. For Residents #15, #23, #48 and #59, there was no documented evidence that the residents had been offered, received, had declined and/or been educated on the influenza immunization for this year's flu season. The evidence includes but is not limited to the following: The facility policy Pneumococcal Vaccine - Resident, dated 1/14/22 documented: on admission, staff will attempt to verify if pneumococcal vaccine status is current. Residents will be offered any pneumococcal vaccine that they have consented to and is eligible to receive based on Center for Disease Control recommendations. The facility policy Influenza Vaccine - Resident, dated 1/14/22 documented: all residents will be offered the influenza vaccine annually during the flu season, October 1st through March 31st. 1.Resident #64 had diagnoses including chronic obstructive pulmonary disease, heart failure, and dementia. The Minimum Data Set Resident assessment dated [DATE], documented the resident was over [AGE] years of age, had severe cognitive impairment, that their pneumococcal vaccine was not up to date and that they had not been offered the pneumococcal vaccine at the facility. Review of Resident #64's electronic medical record revealed no documented evidence that the resident/resident representative had received, been offered, declined, or been educated regarding the pneumococcal vaccine. 2.Resident #15 had diagnosis including dementia, anxiety, and depression. The Minimum Data Set Resident assessment dated [DATE], documented the resident had severe cognitive impairment, and that they had not received the influenza vaccine in the facility for this year's influenza season and did not include the reason why not. Review of Resident #15's electronic health record revealed the influenza vaccine was last administered 10/11/22. There was no documented evidence that the resident/resident representative had been offered, administered, declined, or been educated regarding the vaccine for this year's flu season. 3.Resident #59 had diagnosis including chronic obstructive pulmonary disease, diabetes, and kidney disease. The Minimum Data Set Resident assessment dated [DATE], documented the resident had moderate cognitive impairment and did not receive the influenza vaccine in the facility for this year's flu season due to having received it previously. (continued on next page)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #59's electronic health record revealed that the New York State Immunization Information System form documented that the resident last received the influenza vaccine in 2022. There was no documented evidence in the record regarding if the resident had received, been offered, declined or educated regarding the vaccine for this year's influenza season. 4.Resident #23 had diagnoses including spinal stenosis (a condition where the spinal cord narrows and compresses the spinal column), atrial fibrillation (irregular heartbeat), and depression. The Minimum Data Set Resident Assessment, dated 2/16/24, documented the resident had moderate cognitive impairment, that the resident had not received the influenza vaccine in the facility for this year's influenza season due to it being offered and declined. Review of Resident #23's electronic health record revealed no documented evidence that the resident/resident representative was educated regarding the vaccine or evidence of a declination of when it was offered and declined. During an interview on 3/28/24 at 12:27 PM the Infection Control Nurse, after review of Resident #64's electronic health record, stated they could not find evidence the resident had received or had been offered the pneumococcal vaccine. After review of Resident's #15, #23, #48 and #59 documentation, the Infection Control Nurse stated they could not find verification the residents were offered or declined the influenza vaccine for this year's flu season. In an interview on 3/28/24 at 12:41 PM the Director of Nursing stated the resident's pneumococcal vaccine should be reviewed on admission and offered if they had not received it. The influenza vaccine should be offered during the influenza season and any vaccinations received or declined should be documented in the electronic health record. 10 NYCRR 415.19(a)(3)