STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335382	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Commons on St Anthony, A S N F & Short T R C	3 St Anthony Street Auburn, NY 13021

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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. 48675 Based on observations, record review, and interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for 1 of 2 residents (Resident #196) and for 3 of 8 resident units (Units 3, 5, and 6) reviewed. Specifically, Resident #196's room had personal care information posted in an area visible to other residents and visitors; and Units 3, 5, and 6 had signs on the elevators documenting they were out of order to keep cognitively impaired residents from using the elevators. Findings include: The facility policy, Quality of Life-Dignity, dated 1/10/2023, documented residents were to be treated with dignity and respect at all times. Each resident should be cared for in a manner that promotes and enhances their sense of wellbeing, level of satisfaction with life, and feeling of self-worth and self-esteem. Signs indicating the resident's clinical status or care needs would not be openly posted in the resident's room unless specifically requested by the resident or their family. Discreet posting of important clinical information for safety reasons was permissible if it was taped to the inside of their closet door. Residents would be allowed unrestricted access to common areas open to the public unless it posed a safety risk to the resident. Staff were expected to treat cognitively impaired residents with dignity and sensitivity by addressing the underlying motives or root causes for behavior and not challenging or contradicting the resident's beliefs or statements. 1) Resident #196 had diagnoses including dementia and chronic obstructive pulmonary disease (lung disease). The 8/15/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required partial/moderate assistance with personal hygiene, toileting hygiene, lower body dressing, and was occasionally incontinent of urine. The Comprehensive Care Plan initiated 4/17/2024, documented the resident had occasional bladder incontinence related to activity intolerance. Interventions included clean peri area after each incontinence episode, the resident was not to use briefs, utilize underwear with a pad due to rashes and change with each incontinence episode. The active Kardex (care instructions) documented the resident did not use briefs and was to utilize underwear with a pad due to rashes. Change after each incontinence episode and as needed. (continued on next page)

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 observations on 10/28/2024 at 1:52 PM, 10/29/2024 at 9:33 AM, and 10/31/2024 at 10:19 AM, Resident #196's room had a white sign with black bolded letters on the outside of the closet door that documented, no pullups or briefs per Nurse Manager, only a pad with underwear. During an interview on 11/1/2024 at 9:26 AM, Certified Nurse Aide #34 stated they were assigned to care for Resident #196. They looked at the Kardex to know how to properly care for the resident. The Kardex included no briefs for Resident #196. They thought the sign on the resident's closet door was hung up by the Nurse Manager as a reminder because staff were still putting briefs on the resident even though they had a rash from wearing them. They stated having private information posted in the resident's room could affect the resident and it was not dignified. During an interview on 11/1/2024 at 9:53 AM, Certified Nurse Aide #35 stated they looked at the Kardex daily when caring for residents to know how to properly care for them. They were unsure why the sign was put up in Resident #196's room because all the information was in the Kardex, and staff should look there before caring for residents. They stated the sign was a privacy issue and was not dignified. During an interview on 11/1/2024 at 10:13 AM, Licensed Practical Nurse #36 stated they had seen the sign on the closet in Resident #196's room and it was put up as a reminder, so staff did not use briefs because the resident had a reaction to them and developed a rash. All care information was listed in the residents Kardex. They thought the sign could have been a dignity issue and it should have been put inside Resident #196's closet door or they could put up a sign that reminded staff to review the Kardex before performing care. During an interview on 11/1/2024 at 10:36 AM, Registered Nurse Unit Manager #24 stated all nursing staff had access to the resident's Kardex. The Kardex contained all care information including brief size, transfer status, toileting, safety, and all activities of daily living and was found in the computer and was not posted in resident rooms. They put the sign up in Resident #196's room to remind staff not to use briefs or stock them in their room because they kept getting a rash when they wore them. They stated having a sign that contained private resident information that was visible to visitors and residents was not dignified. 2) During the following observations signs documenting, Stop, Elevator Out of Order covered the elevator buttons outside the elevators: - on 10/28/2024 at 10:36 AM on Unit 3. - on 10/28/2024 at 2:30 PM on Unit 6. - on 10/29/2024 at 9:15 AM on Unit 3. - on 10/29/2024 at 10:06 AM on Unit 5. - on 10/29/2024 at 10:15 AM on Unit 6. - on 10/30/2024 at 8:21 AM on Unit 5. - on 10/30/2024 at 8:55 AM on Unit 6. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 10/30/2024 at 1:13 PM on Unit 3. - on 10/31/2024 at 8:10 AM on Unit 5. - on 10/31/2024 at 2:30 PM on Unit 6. - on 11/1/2024 at 9:03 AM on Unit 5. - on 11/1/2024 at 9:18 AM on Unit 3. The elevators functioned when the buttons were pushed. During an interview on 10/29/2024 at 11:00 AM, the Director of Nursing stated the out of order signs were put on the unit elevators to deter the residents from using the elevators. They did not notify visitors about the signs, and if visitors asked, they would explain the elevators were not out of order. During an interview on 11/1/2024 at 12:17 PM, the Administrator stated they hung the out of order signs over the elevator buttons to deter confused residents from using the elevators. They did not think the signs confused visitors or residents and if the elevators were broken, they would hang the sign on the elevator doors. If alert and oriented residents wanted to leave the units and they had off unit privileges they would just lift the sign, push the button, and use the elevator. During an interview on 11/1/2024 at 11:00 AM, Registered Nurse Unit Manager #60 stated out of order signs were hung on unit elevators to deter residents from using them. Unit 4 did not have a sign because they were able to deter the confused residents on their unit and they thought the sign would confuse alert and oriented residents. They understood why the signs could be considered undignified, but they also understood why some units were using the signs and thought it was for resident safety so confused residents would not try to constantly get on the elevators. During an interview on 11/1/2024 at 9:04 AM, Unit Secretary #61 stated they used the out of order sign to prevent exit seeking residents from getting into the elevators. Occasionally visitors would ask them what they should do if the elevators were out of order, and they would explain why the sign was up and routine visitors would know the elevators were not broken. They had several residents who would try to exit seek but they had wander alert bracelets and if they asked how to get off the unit, they would explain they needed a friend to go with them. During an interview on 11/1/2024 at 10:05 AM, Licensed Practical Nurse #26 stated the out of orders signs were on every unit and they were used to deter dementia residents from trying to leave the unit. Most of the confused residents had wander alert bracelets so the alarm would sound if they got onto the elevator, and they would not be able to leave the unit unless staff entered a code. Visitors would frequently ask the staff if they needed to use the stairs to leave the unit, but once they explained why the sign was there, they were usually understanding. They thought the signs were confusing to some of the residents and visitors. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 10:33 AM, Registered Nurse Manager #24 stated the out of orders signs were supposed to be on every unit and they had been up since they had started working there. Visitors frequently asked staff if the elevators were out of order or ask where the stairs were located. They stated staff would explain they were used to deter confused residents from trying to leave the unit. 415.3(d)(1)(i)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 48052 Based on record review and interviews during recertification and abbreviated (NY00318491) surveys conducted 10/28/2024-11/1/2024, the facility did not ensure residents had the right to receive visitors of their choosing at the time of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that did not impose on the rights of another resident for 1 of 1 residents (Resident #243) reviewed. Specifically, the facility restricted Resident #243's family member's visitation based on the resident's healthcare proxy's wishes. Findings include: The facility policy, Visitation Policy, dated 5/23/2023, documented unless visitation was suspended to comply with applicable laws or regulations, the residents were permitted to receive visitors 24/7 subject to the resident's wishes and the protection of the rights of other residents in the facility. The facility recognized the resident's needed to maintain contact with the community they lived and/or were familiar with and they could have visitors as they wished. The facility provided 24-hour access to all individual visiting with the consent of the resident. Visitation would be subjected to reasonable restrictions that protected the security of the facility's residents which included: limiting or supervising visits from person who were known or suspected to be abusive of exploitative to a resident, denying access to individuals who are found to have been committing criminal acts, and denying access to visitors who were inebriated, disruptive, physically, or verbally abusive to the staff. The facility policy, Resident Rights & Notice of Resident Rights and Responsibilities, dated 4/30/2024, documented residents of the facility had the right to visit and be visited by others from outside the facility. Resident #243 had diagnoses including unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The 10/1/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was usually understood, was usually able to understand others, and felt it was important to be able to choose their own bedtime and have family involved in their care planning. The 1/13/2024 Comprehensive Care Plan documented the resident was dependent on staff and family for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations. Interventions included to encourage ongoing family involvement and to invite family to attend special events, activities and meals, and the resident's preferred activities were visiting with family and other alert people. The 2/15/2024 revised plan of care documented the resident had a very supportive family and was not to leave the unit with their adult child. Interventions included to praise family involvement and visits, be available to provide support and discuss concerns, and to invite them to share knowledge and history of the resident. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/12/2024 Social Worker #16 progress note documented they called the resident's healthcare proxy to notify them one of the resident's adult children was visiting late at night. The resident's roommate had expressed being uncomfortable about having a visitor in the room at night. The healthcare proxy was informed that the facility did not permit visits late at night and the healthcare proxy agreed the resident's adult child should not visit late at night. The adult child was contacted and informed late night visits were not permitted at the facility. The 4/2/2024 Social Worker #16 progress note documented the resident's adult child called and inquired if the resident was on full comfort measures as their adult sibling stated the resident was. They wanted to be able to come and visit the resident at any time since the resident was dying. Social Worker #16 stated they could not release details as the adult child was not the healthcare proxy and directed them to contact their adult siblings. The adult child stated they wanted to spend as much time with the resident as they were able if the resident was dying and inquired about coming whenever they wanted, especially at night when they were off work. Social Worker #16 stated they would ask but it likely would not change. The 4/8/2024 Social Worker #16 progress documented the resident was full comfort care due to not taking medications or eating. There was no documented follow up with the resident's adult child about the request to visit when they wanted. The 10/11/2024 Social Worker #16 progress note documented the resident was able to make their basic needs known. During an interview on 10/31/2024 at 8:47 AM, Social Worker #16 stated they had problems with Resident #243's adult child sleeping next to the resident in bed, changing the resident, and being in the common area until 11:00 PM at night. They stated they discussed with the resident's adult child they were not able to change the resident or lie in bed with the resident and the facility put limitations on the resident's visiting hours. The adult child was told they could not visit after 8:00 PM. During an interview on 11/1/2024 at 12:17 PM, the Administrator stated their doors lock at 9:00 PM or 10:00 PM at night and they opened at 6:00 AM. Visitors could visit late at night for special reasons like a resident being at the end of life. They stated for Resident #243's situation, there were a lot of family dynamics and the resident's healthcare proxy felt it was inappropriate for the adult child to visit the resident late at night. They stated the resident's adult child would lie next to the resident in bed and the healthcare proxy thought it was inappropriate and so did the facility staff. The facility was not concerned the resident's adult child would abuse or hurt the resident. They stated the facility tried to accommodate residents' visitors, but the resident's adult child was waking the resident up and turning on the lights to visit. The resident's adult child stated they visited later at night due to their work schedule. There were never any concerns voiced by the resident or adverse behaviors noted to the resident's adult child's late visits. They stated they would restrict resident visitors based on the healthcare proxy's wishes if the resident was not able to make their needs known. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/24 at 2:16 PM, the Social Services Director stated the facility did not have visiting hours. They stated the doors were locked at 8:00 PM or 9:00 PM but visitors could push the button to be let in. They stated as a rule, the social workers should not tell resident families they were not allowed to visit late at night or after 8:00 PM. They stated they did not specify time frames for visits and if they did, all cases were discussed with administration prior to a decision. If a family member wanted to visit late at night and the roommate of their family member did not like having visitors at that time, there were other spots for the resident and family to visit. They stated they had no indication that Resident #243's adult child was being hurtful in anyway or that the adult child's late-night visits bothered or upset the resident. They stated they did not normally restrict visitors based on a healthcare proxy's wishes but there were special circumstances. 10 NYCRR 483.10(f)(4)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 48052 Based on record review and interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure the individual financial record was available to the resident through quarterly statements and upon request for 2 of 2 residents (Residents #93 and #198) reviewed. Specifically, Residents #93 and #198 were not provided with personal fund statements within 30 days after the end of the quarter, and upon request. Finding include: The facility policy, Resident Fund Policy and Procedures, dated 10/1/2015, documented the Resident Banker was on duty Monday- Friday from 9:00 AM-12:00 PM and from 1:00-3:00 PM; resident fund statements were delivered to the resident and/or authorized representative quarterly and showed the prior quarter's transactions; and the resident and/or authorized representative could request balance and/or printed statements during banking hours. Resident #93 was admitted with diagnoses including Parkinson's Disease (a progressive neurological disorder). The 10/23/2024 Minimum Data Set assessment documented the resident had intact cognition and required moderate assistance with most activities of daily living. Resident #93's 10/26/2023 Comprehensive Care Plan documented the resident was alert and oriented and able to make decisions regarding their care. Interventions included decision making was encouraged. Resident #198 was admitted with a diagnosis including Sjogren syndrome (an autoimmune disorder). The 10/19/2024 Minimum Data Set assessment documented the resident had intact cognition and required supervision to moderate assistance for most activities of daily living. Resident #198's 10/26/2023 Comprehensive Care Plan documented the resident was alert and oriented and able to make decisions regarding their care. Interventions included decision making was encouraged. During an interview on 10/28/2024 at 4:27 PM, Resident #198 stated they had an account with the facility but had not received a statement since admission (approximately 8-9 months ago). They did not know how to access their money in the facility account and when they asked the social worker, they were only given an account balance. During an interview on 10/28/2024 at 4:28 PM, Resident #93's family member stated they did not get statements and they had to ask for a balance quarterly. During an observation on 10/29/2024 at 2:07 PM, signage outside the bank door documented resident bank hours were Monday-Friday 8:00 AM to 4:00 PM. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 11:02 AM, Financial Associate #5 stated the resident bank was usually open from 8:00 AM to 4:00 PM and they often stayed until 4:30 PM. They took a lunch break from 12:00-12:30 PM but let security know they could tell the residents to come to the bank at that time as well. Usually when a resident came into the facility, they received a packet and a form to sign if they wanted to open a personal funds account. They provided residents a quarterly savings statement and it went to the resident or the family. Some of the alert residents had their statement sent to their social worker and the social worker dispersed it. If the statements were to go to the family, they were responsible to send them in the mail. They told all families they did not have to wait for a quarterly statement, and they could come in and ask for a statement with their balance at any time. For alert and oriented residents, they entrusted the social workers handed them out when they put a note on the envelope that said, please give to the resident. Resident #93's and Resident #198's statements went to Social Worker #15. They reviewed the electronic record of each resident and knew which residents got a statement and which residents had their statement sent to their power of attorney, or they checked with the social worker. They stated Accounting Manager #4 handed out statements during the last 6 months, and maybe some were missed. During a telephone interview on 10/30/2024 at 11:30 AM, Accounting Manager #4 stated they were not really in charge of the resident funds account but helped Financial Associate #5. During an interview on 10/30/2024 at 11:37 AM, [NAME] Manager #63 stated there was no cap on how much Medicaid residents could have in their account. They stated that Financial Associate #5 oversaw the tracking, the deposits, and the personal funds account. During an interview on 10/30/2024 at 12:08 PM, Social Worker #16 stated they sometimes took the resident's money down to the bank for them and brought the receipt book up and had the resident sign it or brought down their checks. They gave the residents their monthly statement or a balance. They taught residents how to open a personal account and how to deposit into and withdraw money from their account if there was a store they wanted to go to or something they wanted to purchase. If the resident did not remember their account usually the family was on top of the account information. During the off hours, they had a locked box with envelopes they could deposit into. Financial Associate #5 kept track of the money. They had not handed statements to Resident #93 and #198. Resident #198 just recently asked for a balance statement. They stated Accounting Manager #4 sent them quarterly statements via electronic mail, and they handed out the ones that went to the residents. 10NYCRR 415.26(h)(5)(iii)

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 48052 Based on record review and interviews during the recertification survey conducted 10/28/2024 -11/1/2024, the facility did not ensure that a surety bond (an agreement between the facility, the insurance company, and the resident wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds the facility holds, safeguards, manages, and accounts for) was purchased in the amount equal to or greater than the total resident funds to assure the security of all personal funds of residents deposited with the facility for 239 of 296 residents with personal funds accounts. Specifically, the facility's surety bond was for an amount less than the total of all resident personal fund accounts being held by the facility. Findings include: The facility policy, Resident Fund Policy and Procedures, dated 10/1/2015, documented the facility shall hold, safeguard, manage and account for resident personal funds placed in its care. The facility would ensure compliance with Federal, State, and County resident fund requirements. There was no documented facility policy regarding the surety bond for resident funds. The facility resident Personal Funds Account balance for resident accounts held by the facility totaled: - $309,021.74 on 9/16/2024. - $309,980.04 on 10/1/2024. - $303,807.41 on 10/15/2024. - $286,256.24 on 10/30/2024. The Surety Bond dated 8/10/2023 for coverage dates from 11/8/2023 to 11/8/2024 documented the resident Personal Funds Accounts were insured for $250,000.00. There was no documented evidence the facility had a surety bond to cover the Personal Funds Account total managed by the facility. During an interview and record review on 10/30/24 at 11:41 AM with Financial Associate #5 and Accounting Manager #4, Financial Associate #5 stated the Resident Funds Account total was $268,072.82. Accounting Manager #4 stated they had a surety bond for the Resident Funds Account, and they paid an extra $5,000 a month for it. They would have to look up the surety bond to see how much it covered. During an interview and record review on 10/30/24 at 3:06 PM, the Chief Operating Officer stated their coverage for the Resident Personal Funds Account was $250,000. They stated the amount fluctuated and the question was the timing with when social security money was deposited into resident accounts. They were unaware of what the balance consistently was. The Accounting Manager and Comptroller tracked the amount in the resident accounts. (continued on next page)

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 11/01/24 at 1:03 PM, the Corporate Treasurer stated they managed the treasury for the company's banking relationships. They oversaw anything that came through for the accounts, the cash flows, fraud, or abuse claims regarding the accounts, and until recently, all insurance aspects for the company accounts. They stated they did not check to make sure the Resident Funds Account total did not exceed the surety bond on a regular basis and was unaware they were required to. 10 NYCRR 415.26(h)(5)(v)

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 49448 Based on interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure the rights of citizenship, including the right to receive mail, were maintained for 296 of 296 residents residing in the facility. Specifically, mail was not delivered to residents on Saturdays, thereby denying all residents the same rights provided to other citizens of the general community. Additionally, 3 of 6 anonymous residents present at the resident group meeting stated their mail was opened prior to it being delivered to them. Findings include: The facility policy, Resident Mail, dated 2/27/2024, documented residents received their mail promptly and unopened unless requested in writing by the resident or designated representative. Any front desk deliveries were delivered to the resident promptly. On Saturdays, the nursing supervisor delivered mail to the units during rounds. Staff then distributed the mail to residents on the same day. The facility policy, Resident Rights & Notice of Resident Rights and Responsibilities, dated 4/30/2024, documented residents had a right to access mail. The nursing facility ensured residents had a right to exercise their rights without interference from the facility. During a resident group interview on 10/28/2024 at 2:17 PM, 6 of 6 anonymous residents stated mail was not delivered to them on Saturdays because the social workers did not work on Saturdays. Three residents stated they received mail that had been opened prior to it being delivered to them. During an interview on 11/1/2024 at 10:12 AM, Certified Nurse Aide #9 stated they did not know the process of mail delivery and had never seen mail passed out to the residents. During an interview on 11/1/2024 at 11:00 AM, Certified Nurse Aide #10 stated mail was delivered to the front desk and the front desk called the floor and alerted the floor the mail had been delivered. Sometimes the person at the front desk brought the mail to the unit, sometimes a staff member went to get it and the unit secretary, or the certified nurse aides delivered it to the residents. During an interview on 11/1/2024 at 11:31 AM, front desk Security Site Supervisor #12 stated they worked Monday through Friday and sorted the mail by floor and placed it in that floor's folder. Each floor had an assigned social worker that came to get the mail from the folder after it was sorted. They stated Security Officer #11 worked on weekends. During an interview on 11/1/2024 at 11:35 AM, front desk Security Officer #11 stated they worked on Saturday and Sunday. On Saturday when the mail came, they sorted the mail by floor. Anything that looked like an official document went into the folder for the social worker of the floor the resident resided on. If it looked like a card or a personal item that was handwritten, the nursing supervisor was notified and would deliver that piece of mail to the resident. (continued on next page)

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 11/1/2024 at 11:47 AM, the Director of Social Work stated the front desk sorted mail by floor and the assigned social worker delivered it. The social workers were the only ones who knew if the facility was the representative payee for the resident. If so, the social worker got the resident's bills. Residents that did not have the facility as their representative payee received their own mail. The social workers did not work on Saturdays, so residents received greeting cards on Saturdays that were distributed by the Nursing Supervisor. All other mail went into folders to be sorted by the social workers on Monday. The residents should receive mail on Saturdays as it was their right. It was not fair the residents had to wait until Monday to receive their mail. This was the residents' home, and they should have the same rights as anyone. 10NYCRR 415.3(d)(2)(i)

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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. 35045 Based on observation, record review, and interview during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident to meet medical and nursing needs identified in the comprehensive assessment for 1 of 3 residents (Residents #20) reviewed. Specifically, Resident #20 did not have footrests and lateral supports while in their scoot chair (a specialty chair used to improve positioning and mobility) as planned. Findings include: The facility policy, Turning and Repositioning, dated 3/27/2024, documented the resident would receive the required assistance for repositioning based on their assessment from the interdisciplinary team. Repositioning would be provided to prevent the development of secondary conditions that could infringe on the resident's ability to function at the highest practical level attainable. The certified nurse aide would provide turning and repositioning per the care plan and document in the electronic medical record plan of care. Nursing would monitor and adjust the intervention as needed and ensure documentation compliance. Resident #20 had diagnoses including dementia, abnormal posture, and muscle weakness. The 6/25/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, was dependent for activities of daily living, was non-ambulatory, used a wheelchair, and did not have functional limitation in range of motion in their arms or legs. The Comprehensive Care Plan initiated 9/8/2021 and revised 10/22/2024 documented the resident was at risk for falls related to confusion, gait/balance problems, and incontinence. Interventions included assure resident was in reclined/low position when in their scoot chair, place resident in scoot chair when awake, and keep resident in the lounge area when in the scoot chair, and therapy trigger for resident positioning in scoot chair. The Comprehensive Care Plan initiated 8/22/2021 and revised 10/22/2024, documented the resident required assistance with self-care related to activity intolerance. Interventions included utilizing footrests while in scoot chair, bilateral lateral supports in scoot chair, range of motion for bilateral hips, resident should be kept in lounge area when in scoot chair and out of bed for all meals. The undated care instructions documented assure resident was in reclined/low position when in scoot chair, keep in lounge area when in scoot chair, and utilize footrests while in scoot chair. The 2/2/2024- 2/15/2024 Occupation Therapist #30 assessment documented the resident's discharge recommendation included a scoot wheelchair and use of bilateral supports. Nursing would continue to monitor and notify therapy with any concerns. The 7/5/2024 Registered Nurse Unit Manager #29 documented the resident was discussed during care planning with the daughter present on the phone. There was concern about the resident leaning forward in their scoot chair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following observations of Resident #20 were made: - on 10/28/2024 at 11:25 AM, sitting in a scoot chair in the lounge area, leaning forward with their head in their lap. - on 10/28//2024 at 12:01 PM, sitting in their scoot chair at the dining room table leaning forward with their feet touching the floor. At 12:56 PM, sitting in their scoot chair, bent forward touching the floor with their hands. At 1:09 PM, leaning to the left side while staff assisted them with their meal. At 1:51 PM, the resident was brought to the lounge area in their scoot chair and staff did not reposition the resident. - on 10/29/2024 at 9:51 AM, sitting in their scoot chair in the lounge area sitting upright. At 10:16 AM, leaning over to the left side of chair with their head hanging off the side of the chair. At 10:20 AM, Certified Nurse Aide #28 moved the resident in their scoot chair closer to the television and did not attempt to reposition the resident to the middle of the chair. The resident leaned forward in the chair. At 2:36 PM, the resident remained in the lounge area, leaning forward (head on their knees) in the scoot chair. - on 10/30/2024 at 8:23 AM, sitting in their scoot chair in the lounge area, asleep with their head leaning on the right arm rest. At 9:20 AM, Licensed Practical Nurse #33 brought the resident into the lounge area and put the resident in front of the television. At 9:40 AM, the resident was bent forward in their scoot chair, and Social Worker #16 was talking to another unidentified resident that was seated close by. At 11:49 AM, the resident remained in the scoot chair bent forward touching their feet with their head on their lap. - on 10/3/12024 at 12:15 PM, and 1:34 PM, sitting in the scoot chair in the dining room leaning forward with their hands on their feet. During an interview on 10/31/2024 at 1:44 PM, Certified Nurse Aide #31 stated the resident required a mechanical lift from the bed and should be repositioned every 2 hours when in bed. They were not sure about repositioning in the chair. The resident was not contracted but liked to lean over and needed to be repositioned so they would not fall. During an interview on 10/31/2024 at 1:47 PM, Certified Nurse Aide #32 stated they routinely cared for Resident #20 and the care instructions said the resident should be repositioned every 2 hours while in the chair and in bed. During a telephone interview on 11/1/2024 at 8:51 AM, the resident's family member stated they talked to the staff about the positioning of the resident, and it was heart breaking to see the resident in those positions. The resident had scoliosis (curvature of the spine) and they were not sure if the resident had pain. The staff tilted the chair back because the resident had fallen forward out of the scoot chair in the past. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 9:23 AM, Occupational Therapist #30 stated Resident #20 was last seen in February 2024, from February 2 until February 15. The resident flexed forward on their own in the chair. Nursing staff needed to assist the resident with the lateral supports. There were two small black pieces that should have been next to the resident on each side to prevent the resident from leaning. The resident required total assistance from staff with positioning upright. The supports were removable, they had trialed a pillow a long time ago but that ended up on the floor. The resident was screened in 9/2024 and nursing decided they did not need therapy. Nursing was responsible for repositioning the resident as needed. During an observation on 11/1/24 at 9:52 AM, Resident #20 was sitting in their scoot chair in the lounge area with bilateral side support to right side only. There was no left lateral side support. During an interview on 11/1/24 at 9:53 AM, Certified Nurse Aide #27 stated Resident #20 was supposed to be repositioned every 2 hours to make sure they were sitting upright in the chair. The resident was supposed to be checked on and repositioned every 2 hours when in the scoot chair. They did not have to document the regular positioning or checking the resident every 2 hours. During an interview on 11/1/24 at 10:15 AM, Registered Nurse Manager #29 stated the resident should have had two side supports and be reclined back in the scoot chair if they were not eating and the brakes should not be locked. The resident always leaned forward and pulled their knees up in the chair. They stated when the resident was repositioned that was considered range of motion to the hips. There was a 2-hour check and change order while in the bed but there was nothing documented for repositioning while out in the lounge sitting in the scoot chair. They did not have the bilateral support in place, the right one was in the closet, and they were not sure where the left one was placed. Therapy had just brought up a new left side support. They stated they had seen the resident in the forward and leaning position several times during the past few days and did not reposition the resident. The resident was always sitting in a strange position, and they were used to seeing the resident that way. 10NYCRR415.12(e)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49448 Based on observations, record review, and interviews during the recertification and abbreviated (NY00356778) surveys conducted 10/28/2024-11/1/2024, the facility did not ensure residents received treatment and care in accordance with professional standard of practice for 1 of 2 residents (Residents #1 and #232) reviewed. Specifically, Resident #232 had bilateral (both sides) above the knee amputations and the facility did not follow up on a prosthetics (artificial limb) referral timely and Resident #1 experienced an emotionally distressing event that was not addressed timely. Findings include: The facility policy, Request for Consultation and Follow Up, dated 1/22/2024, documented upon return from an appointment, the nursing staff conveyed the results of the consultation to the attending provider and the recommendations for additional interventions or follow-up. The consult form was dated and initialed and indicated it had been reviewed by nursing. The facility policy, Resident Rights and Notice of Resident Rights and Responsibilities. dated 4/30/2024, documented the resident had a right to access services outside the facility. The facility policy, Adverse Incidents and Incident Report, dated 10/21/2024, documented the facility ensured the residents environment remained as free of accident hazards as possible. Staff responded to the immediate needs of the resident involved in the adverse incident and immediately notified the nursing supervisor and/ or registered nurse on the unit. 1) Resident #232 had diagnoses including encounter for orthopedic aftercare following surgical amputation and acquired absence of left and right legs above the knee. The 8/14/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and had functional limitation of both lower extremities. The Comprehensive Care Plan initiated 8/27/2024 documented the resident had an amputation of the left and right legs above the knee related to venous insufficiency (improper blood flow of the veins). Interventions included position was changed frequently, and periods of rest were alternated with activity out of bed. Dependent edema (fluid buildup in tissues due to gravity), flexion deformity (loss of joint motion), and skin pressure areas were to be prevented. The 8/8/2024 hospital discharge summary documented a right above the knee amputation was done on 7/26/2024 and a left above the knee amputation was done on 8/2/2024. Follow-up appointments with vascular surgery were scheduled for 8/19/2024 and 9/9/2024. The 8/19/2024 Vascular Surgery Consultation Sheet documented the bilateral above the knee amputation sites were healing well. The 9/9/2024 Vascular Surgery Consultation Sheet documented bilateral above the knee amputations were now healed and the staples were removed. Recommendations included to follow up with vascular surgery as needed and a referral was placed to the prosthetics department who would call to schedule. The consultation sheet was signed as reviewed by Registered Nurse Manager #19. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/10/2024 Registered Nurse Manager #19 progress note documented the resident was seen at vascular surgery on 9/9/2024. Per the consultation sheet bilateral above the knee amputations were now healed and the staples were removed, and the resident tolerated the procedure well. Follow up was as needed with vascular and a referral was placed to the prosthetics department, they would call to schedule. There was no documented evidence of an appointment or follow-up communication with the prosthetics department. During an interview on 10/29/2024 at 8:52 AM, Resident #232 stated they were waiting for an appointment for prosthetics for their bilateral leg amputations. They had an appointment in September but had not heard anything since. They thought the facility would let them know when the appointment was scheduled. During an interview on 11/1/2024 at 9:57 AM, Unit Secretary #20 stated they did not know anything about an appointment for prosthetics for Resident #232. The unit secretary to do list was on a clipboard used to communicate progress with the two other unit secretaries. The list did not include if any calls were made to follow-up on the prosthetics referral made by the vascular surgery office on 9/9/2024. Referrals were normally followed up on after a couple of weeks. They checked with Unit Secretaries #21 and #22 who confirmed they did not know anything about this referral either. During an interview on 11/1/2024 at 10:15 AM, Registered Nurse Manager #19 stated they signed the consultation sheets after appointments. They signed the 9/9/2024 vascular surgery consultation sheet. Their progress note stated the referral for prosthetics was sent by vascular surgery. This should have been followed up on within a couple of weeks and they were not sure why it was not. The prosthetics appointment was important to Resident #232 for their mobility, dignity, and mental health. During an interview on 11/1/2024 at 11:58 AM, the Director of Therapy stated Resident #232 had worked with therapy and was discharged . They were aware the resident wanted prosthetic legs and had voiced the goal of walking. The goal for the resident was to achieve the highest level of functioning and they deserved the chance to try. 2) Resident #1 had diagnoses including anxiety disorder, mild intellectual disabilities, and cerebral palsy (a neurological disorder that affects movement). The 2/23/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required substantial/ maximum assistance with bed mobility, and was dependent for transfers. The resident's face sheet documented the resident's representative was the responsible party. The Comprehensive Care Plan initiated 9/9/2021 documented the resident had potential for impairment of skin integrity. Interventions included an alternating pressure air mattress (a specialized mattress with an electronic air pump used for pressure relief). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan initiated on 8/6/2024 by Social Worker #41 documented the resident had a psychosocial well-being problem (potential) related to an incident (7/21/2024) when their bed made a loud noise, accompanied by a flash which startled the resident who had an intellectual and developmental disorder diagnosis. Interventions included being cautious of loud noises and bright flashes around the resident and family and social work were to be notified of any events in the future as soon as they happened. There were no documented nursing progress notes addressing an incident with the resident's bed on 7/21/2024. There was no documented evidence the resident was assessed after the incident. During an observation on 10/28/2024 at 10:31 AM, Resident #1 was lying in their bed on their right side. There were fall mats on both sides of the bed and an electric powered air mattress was in use. During a telephone interview on 11/1/2024 at 8:04 AM, Resident #1's representative stated they had visited the resident on 7/21/2024. They were outside the resident's room in the hallway when Certified Nurse Aide #42, Certified Nurse Aide #43, and Licensed Practical Nurse #45 were in the resident's room. The fall mats were lodged between the wall and the head of the bed. To pull out the fall mats, the bed was pulled over the air mattress cord connected to the outlet behind the head of the bed. This created a loud noise and a flash of light, and the resident verbalized call the fire truck! call the police!. Certified Nurse Aide #42 explained to them what had happened. They asked Licensed Practical Nurse #45 if they had made an incident report and were told it was not needed because the resident was not hurt. For the next several days, the resident was fearful, jumped with any noise, and verbalized to them whew, me scared. Social Worker #41 was not made aware of the event until a week later when they informed them. Social Worker #41 verbalized they were surprised they were not notified so they could provide emotional support to the resident. The resident should have had the opportunity to talk with the social worker. During an interview on 11/1/2024 at 10:45 AM, Certified Nurse Aide #44 stated Resident #1 became startled when there was a loud noise. They were not aware of any incidents that may have triggered this. During a telephone interview on 11/1/2024 at 1:17 PM, Licensed Practical Nurse #45 stated the resident was scared during the event because Certified Nurse Aide #42 had jumped. The resident would get agitated, nervous, and upset about loud noises. They called their Registered Nurse Supervisor #46 after the event, and they came to see the resident. They thought Registered Nurse Supervisor #46 had completed an incident report. During an interview on 11/1/2024 at 2:05 PM, Social Worker #41 stated they were not immediately notified of the event on 7/21/2024. It happened on a weekend, and they were not notified until the following Monday. There was no documented incident or behavior note that would have alerted them. As soon as the resident's representative informed them of the event, they went to see the resident. They should have written a progress note when they saw the resident, but they verified there was no progress note. They stated they updated the resident's care plan the day they had gone to speak with them (8/6/2024). The resident's representative knew them best but by the time they had seen the resident, they seemed to be at their baseline. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 2:24 PM, the Director of Nursing stated they were notified by Registered Nurse Supervisor #46 about the event on 7/21/2024. An accident/ incident report was not necessary because the resident was not hurt. Emotional distress should be addressed and would be documented in a progress note and then discussed in morning report. Registered Nurse Supervisor #46 should have entered a progress note about the incident. The Nurse Manager would have seen that and notified the social worker. If emotional distress was not addressed timely, it could negatively affect the resident's mood or appetite. 10NYCRR 415.12 50561

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50561 Based on observation, record review, and interview during the recertification and abbreviated (NY00347746) surveys conducted 10/28/2024-11/1/2024, the facility failed to ensure a resident with an indwelling catheter (a tube inserted into the bladder to drain urine) received the appropriate care and services to prevent urinary tract infections for 1 of 1 resident (Resident #238) reviewed. Specifically, Resident #238's urinary drainage collection bag was not positioned below the level of the bladder to promote free urine flow (allows urine to back flow into urinary tract). Findings include: The facility policy, Catheter Care Indwelling Urinary Catheter, revised 12/2023, documented the urinary drainage device drainage bag was positioned below the level of the bladder at all times and tubing was positioned to prevent urine reflux toward the bladder. The facility policy, Urinary Tract Infection Prevention and Catheter Use and Care, dated 12/12/2023, documented leg bags (a small urine collection bag attached to the leg) were only used if the resident walked or was on an ambulation program. A leg bag must be worn below the level of the bladder. Resident #238 had diagnoses including history of urinary tract infections, resistance to multiple antibiotics, and retention of urine. The 10/10/2024 Minimum Data Set assessment documented the resident had intact cognition, used an indwelling urinary drainage device, and had a urinary tract infection in the last 30 days. The Comprehensive Care Plan revised 9/20/2024 documented the resident had an indwelling urinary catheter. Interventions included the catheter bag and tubing were positioned below the level of the bladder and leg bags were used only for residents who were able to ambulate when out of bed. The 10/3/2024 hospital discharge summary documented the resident was admitted to the hospital on 9/28/2024 with a diagnosis of sepsis secondary to complicated urinary tract infection. The 10/8/2024 hospital discharge summary documented the resident was admitted to the hospital on 10/4/2024 with a diagnosis of multifactorial metabolic encephalopathy (a brain disorder) due to urinary tract infection. During an observation on 10/29/2024 at 3:11 PM, the resident was lying flat in bed with a leg bag attached to their upper thigh. The position of the leg bag did not allow gravitational flow of urine from the catheter. During an observation on 10/30/2024 at 9:09 AM, the resident was sitting upright in their standard wheelchair using their feet to self-propel. The outline of the leg bag was seen and was attached to the resident's left upper thigh, parallel with the level of the bladder. The position of the leg bag did not allow gravitational flow of urine from the catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 9:45 AM, Resident #238 stated no one discussed the risk associated with urine backflowing if the collection bag was not positioned below the level of the bladder. During an interview on 11/1/2024 at 11:52 AM, Infection Preventionist #38 stated urinary drainage bags should be below the waist. If they were not below the waist this could cause the urine to back flow to the bladder and cause a urinary tract infection. During an interview on 11/1/2024 10:04 AM, Certified Nurse aide #47 stated they switched residents' urinary drainage bags to leg bags in the morning for those residents who walked. They always positioned the leg bag up high on whichever leg that had the anchoring device on it. To prevent pulling on the catheter, they never placed the bag low on the leg. Resident #238 had a catheter and switched between the urinary drainage bag and the leg bag daily. The resident went back to bed after breakfast and sometimes after lunch and kept the leg bag on when they laid down in bed. During an interview on 11/1/2024 at 10:41 AM, Licensed Practical Nurse #49 stated leg bags were for residents who walked and regular urinary drainage bags were for those who did not. Drainage bags should always be kept below the level of the bladder. Resident #238 had a catheter and had a urinary tract infection a little while ago. The resident sat in a wheelchair and went back to bed before lunch and sometimes again in the afternoon. They thought the resident used a regular urinary drainage bag placed under their chair with a cover. If the resident went back to bed with a leg bag urine could back up, cause discomfort, and infection. During an interview on 11/1/2024 at 10:58 AM, Registered Nurse Unit Manager #3 stated leg bags could be used for a resident who sat in a wheelchair only if they were positioned lower than the bladder. The position was important because if the leg bag was not below the bladder, urine would not drain and could cause stagnation and a major urinary tract infection. Resident #238 used a leg bag during the day and switched to a urinary drainage bag at night. They walked very little now and went back to bed during the day. They had multiple urinary bladder infections with sepsis that led to hospitalization s. 10 NYCRR 415.12(d)(1)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Commons on St Anthony, A S N F & Short T R C	3 St Anthony Street Auburn, NY 13021

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 49448 Based on observations, record review, and interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure that residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for 1 of 2 residents (Resident #152) reviewed. Specifically, Resident #152 received hemodialysis treatments at a community-based dialysis center and: - did not have ongoing assessments of their condition and monitoring for complications before and after dialysis treatments; - there was inconsistent communication and collaboration between the dialysis center and the facility; - the resident did not receive a bagged lunch prior to attending dialysis as planned; - the resident frequently did not complete treatments due to discomfort from the mechanical lift pad left under them in their wheelchair, and medical was not notified; - staff documented the resident's permacath (central catheter used for long-term venous access) dressing was dry and intact and the resident did not have a permacath. Findings include: The undated facility policy, Dialysis Care, documented dialysis observation/ assessment and care was documented in the progress notes on each dialysis day, prior to dialysis, and upon return. The vascular access site was examined and assessed for bruit (swooshing sound that indicates the fistula is working) and thrill (a vibration that can be felt when placing fingers over the arteriovenous fistula indicating blood flow). The extremity was examined for adequate circulation, blood pressure obtained, and level of consciousness was assessed. Any dialysis communication in the dialysis book or via telephone conversation was documented in the progress notes. The dialysis book and a bagged meal would be sent with the resident for all treatments. Any correspondence to the dialysis center was documented in the dialysis book. Resident #152 had diagnoses including end stage renal (kidney) disease/dependance on renal dialysis, diabetes, and hemiplegia/ hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (stroke) affecting the left side. The 9/2/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had upper and lower extremity impairment on one side, was dependent for mobility and transfers, had end stage renal disease, and required dialysis treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 9/30/2021 and revised 4/18/2023 documented the resident needed hemodialysis related to renal failure. Interventions included pain medications were administered prior to the resident leaving for dialysis; any signs/symptoms of infection at access site were monitored, documented, and reported; the resident was to be ready in their wheelchair for dialysis Tuesday, Thursday, Saturday at 9:30 AM; and the dialysis binder and bagged lunch were to be sent. The Comprehensive Care Plan did not include the type of dialysis access site the resident had. The 9/11/2024 Physician Assistant #57 orders documented: - Remove dressing from dialysis site at bedtime every Tuesday, Thursday, and Saturday. - Right upper arm: place fingers over resident's fistula (a surgically created connection between an artery and a vein to provide access for hemodialysis) to confirm thrill (motion of blood flowing through it) every day and evening. The order did not include to assess for a bruit. - Transport to and receive from hemodialysis on Tuesday, Thursday, and Saturday at 11:00 AM. Leave at 10:00 AM with [medical transport company] to dialysis center. Have resident ready by 9:45 AM. - Vital signs prior to leaving and upon returning from dialysis two times a day on Tuesday, Thursday, and Saturday. The October 2024 Treatment Administration Record documented the resident attended dialysis on 10/1/2024, 10/3/2024, 10/5/2024, 10/8/2024, 10/10/2024, 10/12/2024, 10/15/2024, 10/17/2024, 10/19/2024, 10/22/2024, 10/24/2024, 10/26/2024 and 10/29/2024. The dialysis communication book documented the following: - On 10/1/2024 there was no documented assessment of the arteriovenous fistula from the facility. The permacath dressing was dry and intact. There was no signature of the nurse that completed this facility report to the dialysis center. The dialysis treatment was ended early. - On 10/3/2024 the permacath dressing was dry and intact. - On 10/5/2024 there was no documented evidence of any communication to/from the facility to the dialysis center. - On 10/8/2024 the permacath dressing was dry and intact. The dialysis treatment was ended early. - On 10/10/2024 there was no documented evidence of any communication to/from the facility to the dialysis center. - On 10/12/2024 the reports were completed. - On 10/15/2024 there was no facility report documented to the dialysis center. The dialysis treatment ended early. - On 10/17/2024 the facility report did not include the resident's name, vital signs, assessment of the arteriovenous fistula or a signature of the nurse that completed the report. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/19/202 the facility report did not include the resident's name, vital signs were incomplete, no arteriovenous fistula assessment, or a signature of the nurse that completed the report. There was no return report from the dialysis center. - On 10/22/2024 the permacath dressing was dry and intact. - On 10/24/2024 there was no documented evidence of any communication to/from the facility to the dialysis center. - On 10/26/2024 the facility report did not include an assessment of the arteriovenous fistula or a signature of the nurse that completed the report. - On 10/29/2024 there was no documented evidence of any communication to/from the facility to the dialysis center. The October 2024 nursing progress notes did not document any evidence medical was notified of incomplete dialysis treatments on 10/1/2024, 10/8/2024, and 10/15/2024 or why the treatments ended early. During an observation and interview on 10/28/2024 at 10:35 AM, Resident #152 was in their room sitting in their wheelchair with a purple mechanical lift pad underneath them. They stated they attended dialysis three days a week, missed lunch on dialysis days, and was not provided with a bagged lunch. They were diabetic and sometimes had problems with low blood sugars. A dialysis book was supposed to go with them to dialysis but sometimes the dialysis center would tell them the facility did not send it. Staff at the facility did not look at their dialysis access site. They stated they often stopped dialysis treatments early because they were in pain from sitting on the mechanical lift pad. They had a sore on their buttocks, and it was uncomfortable to sit on the pad for four hours. Dialysis was aware they stopped treatments early because of pain from the pad and they thought dialysis staff documented that for the facility. During an interview on 10/30/2024 at 10:35 AM, Certified Nurse Aide #44 stated some residents complained about the mechanical lift pad underneath them. Some residents did not have to keep the pad under them if they had been evaluated by therapy and their care plan indicated it. They had not heard Resident #152 complain about the pad under them. They thought the kitchen provided bagged lunches for dialysis residents and put them in the refrigerator, but they were not sure. Resident #152 was diabetic and should take a lunch with them to dialysis, so their blood sugar did not go low. They were not sure if the resident went with a bagged lunch. During an interview on 10/30/2024 at 10:50 AM, Licensed Practical Nurse #58 they routinely cared for Resident #152 and had never provided them with a bagged lunch before dialysis. Resident #152 should have been provided with a bagged lunch, so their blood sugar did not drop. There was also a communication book the nurse was responsible for completing and it included the residents blood pressure and medications taken that morning. The arteriovenous fistula was monitored for bleeding and the presence of the thrill and bruit. Resident #152 complained frequently about being uncomfortable with the mechanical lift pad under them. Licensed Practical Nurse #58 stated they had not told the Assistant Director of Nursing/Interim Nurse Manager about the discomfort but thought they were aware. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 11:12 AM, the Assistant Director of Nursing/Interim Nurse Manager stated vital signs were obtained before and after dialysis. There was a communication book that went with the resident, but they had never looked at it and was not sure what information it contained. Resident #152 did not take a lunch with them. They left the facility shortly after breakfast and returned around 4:30 PM. Staff offered a snack when they returned. They did not think the facility sent lunches, but they probably should, so the resident did not have a hypoglycemic (low blood sugar) event. Resident #152 had an arteriovenous fistula, but it was only monitored if there were issues. They reviewed the dialysis communication book and confirmed the communications were not completed and were inconsistent. It was important the communication between the facility and the dialysis center included the resident's blood pressure and mentation so changes could be assessed. The mechanical lift pads were left underneath the residents unless they had been evaluated by therapy. Staff had not told them Resident #152 complained of discomfort with the pad or they would have triggered physical therapy to assess the resident. They were not aware the resident's dialysis treatments were not always completed due to the discomfort. Resident #152 had a healing sore on their buttocks and the pad probably increased their discomfort. If they knew, they would have alerted the provider as completion of the treatments was important for electrolyte balance. During an interview on 10/30/2024 at 11:51 AM, Physician Assistant #57 stated Resident #152 was very brittle with their diabetes and had fluctuating high and low blood sugars. They should have received three meals a day regardless of if it was a dialysis day or not. Communication between the facility and the dialysis center was important especially if there were any medication changes. They were not aware the resident did not always complete dialysis treatments, but they had heard the resident complain about the pad under them. They would have wanted to be notified of incomplete treatments as this was important for electrolyte balance. During an interview on 10/31/2024 at 9:00 AM, the Food Service Director stated bagged lunches used to go with residents to dialysis, but it had been at least a year since that had happened. They were not sure if there were any current dialysis residents in the building. They had heard the dialysis center did not allow the residents to eat there. Everyone should receive three meals a day for nutrition and enjoyment. During an interview on 10/31/2024 at 9:14 AM, the Director of Dietary stated they heard the residents were not permitted to eat in dialysis. Resident #152 had additional needs for nutrition, was on supplements, and they should have been provided with three meals a day. 10NYCRR 415.12(k)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 48675 Based on observations and interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not post on a daily basis the current resident census and the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, in a prominent location readily accessible to residents and visitors for 5 of 5 days. Specifically, the current daily resident census and nurse staffing schedules were located on the nursing supervisor/staffing office door that was down a hallway off the main lobby and not readily accessible to visitors or residents. Findings include: There was no documented facility policy on nurse staffing posting requirements. The daily nurse staffing information was observed posted on the nursing Supervisor/Staffing office door located down a hallway off the main lobby that was not readily accessible to visitors and residents: - on 10/28/2024 at 4:09 PM. - on 10/29/2024 at 8:15 AM. - on 10/30/2024 at 8:50 AM. - on 10/31/2024 at 7:56 AM. - on 11/1/2024 at 7:39 AM and did not include the daily census. During an interview on 11/1/2024 at 11:03 AM, Staffing Supervisor #13 stated their role was to oversee the staffing department and they made the schedules for the certified nurse aides and licensed practical nurses. The overnight nursing supervisor was responsible for updating the daily nurse staffing numbers. Staffing Supervisor #13 stated they double checked them and ensured they were posted in the morning when they arrived at work. They did not have access to check the daily census and they were not aware the census was not listed on the 11/1/2024 nurse staffing information sheet. They stated they were not aware daily staffing had to be posted in a readily accessible location for both residents and visitors. Visitors would not likely go down the hallway where the Supervisor/Staffing office was when they visited the facility so they would not see them. During an interview on 11/1/2024 at 11:12 AM, the Director of Nursing stated the overnight nursing supervisor completed the daily nurse staffing and hung it on the door for the day shift. The staffing department was responsible for ensuring the daily nurse staffing sheet had the correct nurse staffing numbers, census, and was posted. They were not aware the 11/1/2024 nurse staffing information did not include the census. They stated they were aware the daily nurse staffing had to be posted in a readily accessible location. They thought it accessible on the Supervisor/Staffing door because visitors and residents would go down the hallway to use the bathroom or to go to the bank. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.13

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448 Based on observations, record review, and interviews during the recertification and abbreviated (NY00356778) surveys conducted 10/28/2024-11/1/2024, the facility did not ensure routine and emergency drugs and biologicals were provided to 1 of 1 resident (Resident #1) reviewed. Specifically, Resident #1 was not administered the respiratory syncytial virus vaccine (helps protect against a common respiratory virus, RSV) timely after the vaccine was ordered in 2023 and 2024. Findings include: The facility policy, Resident Immunizations, dated 3/27/2024, documented upon admission resident's immunization records were reviewed. If the resident had not received the respiratory syncytial virus vaccine and was [AGE] years of age or older, the vaccine would be offered, and an order was obtained. Prior to administration, the vaccine information sheet was reviewed with the resident or designated health care proxy and consent was obtained. Resident #1 had diagnoses including heart disease, hypertension (high blood pressure), and allergic rhinitis (seasonal allergies). The 8/24/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had shortness of breath with exertion and lying flat, and was up to date on influenza (flu) and pneumococcal (pneumonia) vaccines. The 4/5/2022 Health Care Declaration and Proxy (a person appointed to make medical decisions) documented the resident's family member was their appointed representative. 2023 respiratory syncytial virus vaccine: The 10/24/2023 Nurse Practitioner #51 medical order documented Arexvy (respiratory syncytial virus vaccine) intramuscular suspension 120 microgram/0.5 milliliter. Inject 0.5 milliliter intramuscularly one time only for the prevention of respiratory syncytial infection. The 10/2023 Medication Administration Record documented Arexy intramuscular suspension 120 microgram/0.5 milliliter, inject 0.5 milliliters intramuscularly one time only for prevention of respiratory syncytial infection with an order date of 10/24/2023. There was no documented evidence Arexvy was administered as ordered. The boxes for 10/24/2023 and 10/25/2023 were blank. The remaining boxes had an x. There was no documented evidence why the vaccine was not administered as ordered. 2024 respiratory syncytial virus vaccine: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/2024 Medication Administration Record documented Arexy respiratory syncytial virus vaccine 0.5 milliliters intramuscularly one time only for immunization for 3 days with an order date of 10/2/2024. There was no documented evidence the vaccine was administered. The boxes for 10/2/2024, 10/3/2024, 10/4/2024, and 10/5/2024 were blank. The Medication Administration Record documented Arexy respiratory syncytial virus vaccine 0.5 milliliters intramuscularly one time only for immunization for 3 days with an order date of 10/5/2024. The boxes for 10/7/2024, 10/8/2024, and 10/9/2024 were blank. The vaccine was administered on 10/10/2024 at 3:16 AM by Licensed Practical Nurse #55. During a telephone interview on 11/1/2024 at 8:04 AM, Resident #1's representative stated approximately 3 weeks ago they received a phone call from the Infection Control Nurse who asked if they wanted the resident to receive the respiratory syncytial virus vaccine. They stated they told the Infection Control Nurse the resident received that vaccine a year ago. The Infection Control Nurse told them the resident did not receive the vaccine a year ago and they were not sure what happened. The resident's representative stated they consented for the resident to receive the vaccine. During an interview on 11/1/2024 at 10:36 AM, Licensed Practical Nurse #52 stated vaccines were ordered by the provider and pharmacy delivered them twice a day, at 8:00 PM and 3:00 AM. The vaccines were put in the medication refrigerator in the medication room. If the vaccine was not given, it would fall off the Medication Administration Record and needed to be reordered. It was important vaccines were given to protect the resident against those illnesses. Licensed Practical Nurse #52 did not know why the vaccine was not administered. During an interview on 11/1/2024 at 10:51 AM, Licensed Practical Nurse #53 stated the pharmacy was alerted electronically when a new order was entered. If it was a one-time dose, such as a vaccine, it needed to be given in a certain window or it would drop off the medication administration record. It was the nurse's responsibility to check the medication refrigerator for the vaccine if it showed up on the Medication Administration Record. It was important the resident received ordered vaccines to prevent infection. During an interview on 11/1/2024 at 11:04 AM, Licensed Practical Nurse #54 stated there was a 3-day window to administer a vaccine. If the vaccine was not administered in those 3 days, it fell off the active Medication Administration Record, and they thought the provider was notified if that happened. It was important for residents to receive vaccines because they lived in a communal setting, and it was their right. They did not recall any issues with Resident #1 receiving the respiratory syncytial vaccine. They thought the Assistant Director of Nursing/ interim Nurse Manager obtained the consents. During an interview on 11/1/2024 at 11:11 AM, the Assistant Director of Nursing/ interim Nurse Manager stated vaccines were handled by the Infection Control Nurse who obtained consents and entered the orders. The vaccines were only on the Medication Administration Record for 3 days. If it was not given, the order would fall off the active Medication Administration Record. It was important that all residents receive ordered vaccinations as they were around many other residents, there were many visitors coming and going, and the residents were elderly and compromised. They had noticed Resident #1 had not received the respiratory syncytial virus vaccine as ordered a year ago and they were not sure why. It looked like a consent was never documented in 2023. They called the Infection Control Nurse and consent was obtained, and the vaccine was reordered in the beginning of October 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 12:13 PM, the Infection Control Nurse stated a resident's vaccination status was checked upon admission. They tracked the vaccine orders and verified they were administered after ordered. They were not tracking the respiratory syncytial virus vaccine in 2023 only the influenza, pneumococcal and COVID-19 vaccines. They now tracked all vaccines including the respiratory syncytial virus. The vaccine was re-ordered in October 2024 because it had fallen off the Medication Administration Record because the resident also received the influenza and COVID-19 vaccines, and the resident's representative wanted them given on different days. It was important the resident received the vaccines because they lived in a close community, there were many visitors, and they were more prone to diseases due to comorbidities. The vaccine was not given in 2023 because it fell through the cracks. During an interview on 11/1/2024 at 12:43 PM, Nurse Practitioner #51 stated the Infection Control Nurse entered the consents and the orders, and then they would sign them off electronically. They did not follow-up if residents had received the ordered vaccinations. Residents should receive ordered vaccines to protect themselves and their peers. It was important for herd immunity. If a vaccine could not be given for any reason, they expected to be notified. They did not recall being notified that Resident #1 did not receive the respiratory syncytial virus vaccine as ordered in 2023. 10NYCRR 415.18(e)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49448 Based on record review and interviews during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure residents were free of any significant medication errors for 1 of 1 resident (Resident #152) reviewed. Specifically, Resident #152 did not receive 24 of 26 doses of physician ordered levetiracetam (brand name Keppra, used to treat seizures). Findings include: The facility policy, Medication Administration Pour-Pass-Sign, dated 8/2021, documented registered nurses and licensed practical nurses appropriately and safely administered and documented medications administered to residents. Refusals were documented in the electronic medical record and included a refusal reason and progress note. The policy did not include details of required documentation if a resident was out of the building during the scheduled medication administration time. Resident #152 had diagnoses including epilepsy (seizure disorder), end stage renal (kidney) disease, and dependence on renal dialysis (removal of waste products from the body when the kidneys don't work properly). The 9/2/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had a seizure disorder or epilepsy, and required dialysis treatments. The Comprehensive Care Plan initiated 4/11/2022 documented the resident had a seizure disorder. Interventions included medications were given as ordered, labs were monitored, and any sub therapeutic or toxic results were reported. The 8/27/2024 Hospital Discharge Summary documented an admission diagnoses of recurrent seizure disorder, questionable up to date on seizure medications. Seizure medication doses were increased and there was a new order for an additional dose of levetiracetam 500 milligrams to be given on dialysis days after dialysis. The 8/28/2024 Physician Assistant #57 medical order documented the resident was to receive levetiracetam 500 milligrams, one tablet by mouth once daily every Tuesday, Thursday, and Saturday for seizures, to be given after dialysis. The August 2024-October 2024 Medication Administration Record documented levetiracetam 500 milligram dose to be given after dialysis on Tuesdays, Thursdays, and Saturdays scheduled for 2:00 PM. The medication administration record documented the following: - on 8/29/2024 the medication was documented as a 1 absent from home without medications. - on 8/31/2024 the medication was documented as 3 absent from home with medications. - on 9/3/2024, 9/5/2024 and 9/7/2024 the medication was documented as 1 absent from home without medications. - on 9/10/2024 there was no documentation (the box was blank) (continued on next page)

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The Commons on St Anthony, A S N F & Short T R C	3 St Anthony Street Auburn, NY 13021

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 9/12/2024 9/14/2024, 9/17/2024, 9/19/2024, 9/21/2024, 9/24/2024, 9/26/2024 and 9/28/2024 the medication was documented as a 1 absent from home without medications. - On 10/1/2024 the medication was documented as a 1 absent from home without medications. - There was no documentation on 10/3/2024. - On 10/5/2024, 10/10/2024, 10/12/2024, 10/15/2024, 10/17/2024, 10/19/2024,10/22/2024,10/24/2024 and 10/26/2024 the medication was documented as a 1 absent from home without medications. All the days marked as a 1 absent from home without medications were the resident's designated dialysis days of Tuesday, Thursday, and Saturday. There was no documented evidence that medical was notified of the missed doses of levetiracetam 500 milligrams after dialysis from 8/28/2024-10/30/2024. There was no documented evidence of why the resident did not receive the ordered levetiracetam after dialysis treatments. During an interview on 10/30/2024 at 10:14 AM, Resident #152 stated they were not sure if they had any recent seizures. They were not given any medications when they got back from dialysis. During an interview on 10/30/2024 at 10:50 AM, Licensed Practical Nurse #58 stated they were frequently assigned Resident #152. They did not initially think the resident had seizure disorder but then decided the levetiracetam was for absence seizures (a type of seizure that can cause brief episodes of disconnection from the surrounding environment) or tremors. It was an important medication and if the resident did not receive it as ordered, they could have tremors or absence seizures. They stated if a resident was not in the building for a scheduled medication it was signed off that they were absent without medications. The resident did have an afternoon dose of levetiracetam. They thought the Medication Administration Record sent a notification to the next shift if this medication was not given. They did not relay this information to the next shift. During an interview on 10/30/2024 at 11:12 AM, the Assistant Director of Nursing/ interim Nurse Manager stated if a resident did not receive 3 doses of a medication in a row, the provider should be notified. Levetiracetam was a critical medication used to treat a seizure disorder. If the medication was not consistently given, the resident could have a seizure. Resident #152 did have a seizure disorder and was ordered to receive an extra dose of levetiracetam on dialysis days. There was an hour before and after a scheduled administration time to give the medication. They were not aware this extra dose was ordered for 2:00 PM and confirmed the resident was not receiving the dose and usually did not get home from dialysis usually until 4:30 PM. They felt the licensed practical nurses should have informed them the resident was not getting this dose because they were not in the building during the scheduled administration time. It was easy to change the time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 11:51 AM, Physician Assistant #57 stated they took care of Resident #152, and the resident was recently hospitalized with seizures. The resident received levetiracetam twice daily and an extra dose on dialysis days after dialysis. The extra dose after dialysis was ordered after the hospitalization for seizures. They were not notified the resident had not received those doses after dialysis. They expected medications to be given as ordered. They were surprised the documentation on the Medication Administration Record for the extra dose on dialysis days showed it had only been given a couple of times since it was ordered and that was not good. The resident had not had another seizure since they returned from the hospital. 10NYCRR 415.12(m)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48675 50561 Based on observation, record review, and interview during the recertification survey conducted 10/28/2024-11/1/2024, the facility did not ensure they established and maintained 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 2 of 3 residents (Residents #238 and #52) and for 1 of 1 staff (Cycle Cleaner #1) reviewed. Specifically, Cycle Cleaner #1 did not practice appropriate use of personal protective equipment or hand hygiene during the cleaning of Resident #644's room who was on precautions for COVID-19; Resident #238's urinary drainage collection bag was not stored in a manner to prevent contamination; and Resident #52's urinary collection bag was observed lying directly on the floor. Findings include: The facility policy, Guideline for Type and Duration for Selected Infections and Condition, dated 5/30/2023, documented in addition to standard precautions, special droplet contact precautions would be put in place for COVID-19 infections. Those precautions included wearing a gown, clean gloves, and protective eyewear when entering the resident room and removing gloves and gown and washing hands before leaving the room. The facility policy, Urinary Tract Infection Prevention and Catheter Use and Care, dated 12/12/2023, documented when a gravity drainage bag or leg bag was removed, it would be rinsed with 1 part vinegar and 3 parts water, soaked for 20 minutes, rinsed with warm water, then hung up to dry; a leg bag/drainage bag cap must be put in place on the end that attached to the urinary drainage device tubing and stored covered in the resident's bedside stand; and the collection bag must be covered at all times for dignity and to prevent it from touching the floor and wheels of wheelchairs. 1) Resident #644 had diagnoses including COVID-19.The admission Minimum Data Set assessment had not yet been completed. The Comprehensive Care Plan did not include COVID-19 or related precautionary measures. On 10/28//2024 Resident #644's COVID-19 test was positive. The 10/28/2024 Nurse Practitioner #59 medical order documented contact/droplet precautions for COVID-19. During an observation on 10/28/2024 at 1:29 PM, Resident #644 had a Droplet Contact Precautions sign hanging outside their room. The sign documented all healthcare personnel must clean hands before entering and when leaving the room; wear a gown when entering the room and remove before leaving; wear an N95 or higher-level respirator before entering the room and remove after exiting; wear protective eyewear (face shield or goggles); and precautions should be followed during room cleaning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 10:27 AM, Cycle Cleaner #1 was cleaning Resident #644's room wearing a gown and a N95 mask. They were not wearing gloves or eye protection. They exited the room, obtained a wash rag from their cart, dipped it in the cleaning solution located on their cleaning cart, reentered the room, wiped down flat surfaces and the doorknob, exited the room, disposed of the cleaning rag in a bag located on their cart, took a trash can liner from the cleaning cart and brought it into the resident's room, exited the room wearing the same gown, no gloves or eye protection, and without performing hand hygiene. They removed their gown in the hallway, placed it in the garbage receptacle located on their cleaning cart, removed the bag from their cart with bare hands, took it down the hall to the soiled utility room, exited the soiled utility, and applied clean gloves without performing hand hygiene. They entered the room adjacent to Resident #644's, brought the garbage out, placed a new wash rag in the same tub of cleaning solution, reentered the same room, wiped down the bedside table, exited the room, and discarded the cloth in a bag located on the cleaning cart. They reentered the room, dried the bedside table, moved to the other half of the room, brought the garbage out to the hall, and delivered both garbage cans back to the room. Cycle Cleaner #1 exited the room, removed their gloves, and did not perform hand hygiene. During an interview on 10/29/2024 at 10:47 AM Cycle Cleaner #1 stated they received training about infection prevention and precautions about a year ago when they were hired. The cleaning buckets were filled with cleaning solution every morning and disposed of at the end of the day.They changed the solution in between those times the cleaning cloths touched something dirty. When they entered a precaution room they wore a gown and gloves and knew what precautions to take by looking at the precaution sign outside the door. Wearing gloves was important because they could contract germs while in the room and then spread it to the next room. Gowns were important for extra protection and could be removed after they left the room. They stated they should have washed their hands with soap and water after cleaning the room and after removing their gloves. They forgot a step when cleaning, so they went back into the room and did not put gloves on. They did not need to wear protective eye wear, but after reading the precaution signage, stated eye wear should have been worn. During an interview on 10/29/2024 at 2:15 PM, Housekeeping Supervisor #2 stated their staff received infection prevention training during the annual mandatory trainings and inservices throughout the year. They expected their staff to be fully gowned and gloved when entering a COVID-19 positive room. They should know what each isolation sign was, what it stood for, and follow its directives. They should wear eye protection if called for, put a bag at the door threshold so they could remove their gown and gloves before leaving the room, and perform hand hygiene after glove removal and before leaving the room. Staff should not go into a COVID-19 positive room without gloves, leave that room without washing their hands, and then go into another room. They could spread COVID-19 all around the building. It was possible that if a contaminated gown was worn into the hallway, it could cause germs to spread into the hallway. During an interview on 10/29/2024 at 2:28 PM, Registered Nurse Unit Manager #3 stated precaution sign directives should be followed by any employee who entered a COVID-19 positive room and included gloves, gowns, a N95 mask, and goggles if any splashing was anticipated, or if the resident was symptomatic. Protective equipment should be removed before leaving the room.Hand hygiene should be performed before entering the room and after removing protective equipment. Gowns and gloves were important to avoid cross contamination and if the same gown and gloves that were worn in a COVID-19 room were worn into the hall the organisms could be brought into the hall and expose others. If an employee did not wash their hands after leaving a COVID-19 room and then entered another room, COVID-19 could spread very quickly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 11:52 AM, the Registered Nurse Infection Preventionist stated they expected all staff, including housekeepers, to wear a N95 mask, gown, gloves, and goggles before entering a COVID-19 positive room and should have removed that equipment and performed hand hygiene before leaving the room. Housekeeping staff should have all the necessary equipment when they entered the room. If a housekeeper left a COVID-19 positive room and went into another room, COVID-19 could spread. Following precautions was important to decrease the spread of infectious diseases and for the protection of the employee, residents, and their loved ones. 2) Resident #238 had diagnoses including history of urinary tract infections, resistance to multiple antibiotics, and retention of urine. The 10/10/2024 Minimum Data Set assessment documented the resident had intact cognition, an indwelling urinary drainage device, and had a urinary tract infection in the last 30 days. The Comprehensive Care Plan revised 9/20/2024 documented the resident had a urinary drainage device. Interventions included when collection bags were removed rinse them out with one part vinegar and 3 parts water, soak the bag for 20 minutes, rinse with warm water, then hang up to dry; and a leg bag/drainage bag cap must be put in place on the end that attaches to the urinary drainage device when not in use. During an observation on 10/30/2024 at 9:09 AM, Resident #238's gravity drainage bag was hanging on a grab bar in the resident's bathroom with 25 milliliters of yellow clear fluid in it. The port that connected to the catheter was not covered. The back of the bag had brown, smeared material on it. No supplies of vinegar were observed. During an observation on 11/1/2024 at 9:45 AM, Resident #238's gravity drainage bag was hanging on the toilet grab bar with approximately 300 milliliters of clear yellow fluid in it. The port that connected to the catheter was not covered. During an interview on 11/1/2024 10:04 AM, Certified Nurse aide #47 stated in the morning when changing from a gravity drainage bag to a leg bag, the gravity drainage bags were disconnected, rinsed out with water and hung on the bathroom bar to dry. There was not a specific cleaning solution used to clean the bags. Some bags had a long, blue cap on the connection port that some staff threw away. The purpose of that blue cap was to prevent contamination. Leg bags also had a protective cover. Resident #238 had a catheter and switched between a gravity drainage bag and a leg bag daily. They observed the resident's gravity drainage bag that was hanging in the bathroom and said there should have been a blue cap on the end and there was nothing protecting it from things getting into it. During an interview on 11/1/2024 at 10:26 AM, Certified Nurse Aide #48 stated there were leg bags and regular gravity drainage bags and when disconnecting a bag, it was emptied and hung on the bar on the side of the bathroom toilet. They did not do anything else to the bag. New gravity drainage bags had a blue cap on the connection port that connected to the catheter that was usually thrown away once opened. They had never seen the cap used after it was opened and no one had told them that it should have been covered. Resident #238's leg bag was hung in their bathroom that morning without a cap on it. After disconnecting the gravity drainage bag, they hung it on the bar next to the toilet. They did not have a chance to empty the urine out of it yet. They did not put a cap on the connection port but did try to anchor it to the bar so that it would not fall or touch something. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 10:41 AM, Licensed Practical Nurse #49 stated when gravity drainage bags where not in use they should be capped and hung in the bathroom on the bar around the toilet. They were unsure what the rinsing or cleaning process was. The cap should have been put in place for infection control reasons. If not capped, and someone used the bathroom and had a bowel movement, particles could spray up when they flushed, and it could contaminate the tubing. They believed bags were dated, changed weekly, and it would come up on the treatment administration record when it was due. If there was a bag in the bathroom that was not capped, they would not use that bag because they did not know if it was contaminated. Resident #238 had a catheter and they recently had a urinary tract infection. During an interview on 11/1/2024 at 10:58 AM, Registered Nurse Unit Manager #3 stated the policy regarding the cleaning of urinary collection bags stated something about vinegar, but the facility used warm soapy water. They expected when the bags were changed, they were cleaned with warm soapy water, capped, and hung to dry. They were unsure how often bags were changed, if they should have been dated, and there was nothing in the administration record that prompted when a bag needed to be changed. The bag should have been replaced if it was hanging without a cap to maintain the integrity of the tubing. Without that barrier, contamination and infection could occur. Resident #238 used a leg bag during the day and switched to a gravity drainage bag at night. The resident had a history of multiple urinary bladder infections with sepsis that required hospitalization . During an interview on 11/1/2024 at 11:52 AM, the Registered Nurse Infection Preventionist stated they were unsure what the policy was regarding bag storage, but they should be stored in clean areas, not in an area that had potential to contaminate the bag and lead to an infection. The drain spout should not have been left open to the air because there was a potential for bacteria to enter. 3) Resident #52 had diagnoses including acute cystitis (inflamed bladder) and neuromuscular dysfunction of the bladder (nerves and muscles that control the bladder do not work properly). The 10/4/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent on staff for toileting hygiene, and had an indwelling urinary catheter. The Comprehensive Care Plan initiated 12/22/2021 documented the resident had a suprapubic catheter (a tube that drains urine from the ballder through a small incision in the lower abdomen) related to neurogenic bladder. Interventions included catheter care every AM and PM, change catheter every 4 weeks, and as needed, position the catheter bag and tubing below the level of the bladder, place a dignity bag on the catheter bag, and monitor for signs and symptoms of a urinary tract infection. The 1/24/2024 physician order documented indwelling suprapubic catheter 24 French (size of tube) 10 milliliter balloon (used to anchor the device in the bladder), monitor patency, output, and urine clarity every shift. The following observations of Resident #52 were made: - on 10/28/2024 at 11:30 AM, lying in bed with their urinary drainage bag resting directly on the bare floor on the window side of the bed. There was no barrier between the drainage bag and the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 10/29/2024 at 9:22 AM, lying in bed with their urinary drainage bag hanging from the window side bed frame, the bed was in the lowest position and the bottom of the bag was resting directly on the bare floor. There was no barrier between the bottom of the drainage bag and the floor. - on 10/31/2024 at 8:53 AM, lying in bed with their urinary drainage bag hanging from the window side bed frame, the bed was in the lowest position and the bottom of the bag was resting directly on the bare floor. There was no barrier between the bottom of the drainage bag and the floor. During an interview on 11/1/2024 at 9:26 AM, Certified Nurse Aide #34 stated they cared for Resident #52 during the day shift on 10/31/20204. They received catheter training upon hire and during yearly in-services. They were responsible for completing catheter care every shift and as needed, emptying the urinary catheter drainage bag, and documenting the output. The drainage bag should always be kept off the floor for infection control reasons and could cause the resident to get a urinary tract infection. They were not aware the drainage bag was touching the floor and if they saw it on the floor, they would have notified the nurse so they could have replaced it with a new drainage bag. During an interview on 11/1/2024 at 9:48 AM, Certified Nurse Aide #35 stated they cared for Resident #52 a few times that week during the day shift. They received catheter training upon hire, yearly, and as needed. They completed catheter care, emptied the urinary drainage bag, and made sure the bag did not overflow. They stated it was important to keep drainage bags off the floor for infection control reasons, the floor was dirty, and Resident #52 could have developed a urinary tract infection. During an interview on 11/1/2024 at 10:08 AM, Licensed Practical Nurse #36 stated the certified nurse aides and nurses received catheter training upon hire, annually, and as needed. The drainage bag should never touch the floor. If the drainage bag was on the floor, it should have been sanitized, switched out for a new one, or some kind of barrier should have been put down between the bag and the floor. They stated floors were dirty with bacteria, which could have caused Resident #52 to develop a urinary tract infection. During an interview on 11/1/2024 at 10:27 AM, Registered Nurse Unit Manager #24 stated nursing staff received training on catheters upon hire, annually, and as needed. Urinary drainage bags were to be hung on the wheelchair or bedframe, so they did not touch the floor. If the drainage bag was on the floor, they would expect nursing staff to pick it up off the floor immediately and clean the bag or change it out for a new one. They stated it was important for Resident #52's drainage bags to be kept off the floor because floors were dirty, and it could put the resident at risk for an infection. During an interview on 11/1/2024 at 11:52 AM, the Registered Nurse Infection Preventionist stated urinary drainage bags should be kept below the resident's waist, in a blue privacy bag, and should not rest on the floor. The floor was dirty, the bag could have been contaminated, and lead to a urinary tract infection. 10 NYCRR 415.19