

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2024
NAME OF PROVIDER OR SUPPLIER  Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Riverside Dr Johnson City, NY 13790	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50561</p> <p>Based on observation, interview, and record review during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure each resident had the right to a dignified existence for 2 of 6 residents (Residents #37 and #137) reviewed. Specifically, Resident #37 was not provided with a requested shower prior to attending a significant family event, and Resident #137's urinary collection bag was visible in plain sight.</p> <p>Findings include:</p> <p>The facility policy, Activities of Daily Living, revised 10/2023, documented the facility would provide each resident the necessary care and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care.</p> <p>The facility policy, Resident Rights and Responsibilities, revised 4/2/2024, documented the facility functioned on the premise that the service it rendered would demonstrate its belief in the dignity and worth of every individual, and the objective of the facility was to provide the resident with optimal nursing and psychosocial care.</p> <p>1) Resident #37 had a diagnosis of osteoarthritis, muscle weakness, and right above the knee amputation. The 5/24/2024 Minimum Data Set documented it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The 8/22/2024 Minimum Data Set documented resident was cognitively intact, was frequently incontinent of bowel and bladder, and required substantial assistance with bathing.</p> <p>The Comprehensive Care Plan last reviewed 8/31/2024 documented a self-care performance deficit related to limited mobility, limited range of motion, and above the knee amputation; and a psychosocial well-being problem due to alteration in mood and behavior. Interventions included dependence for bathing and offer choices related to care routine.</p> <p>The 8/30/2024 Social Worker #33 progress note documented the resident was preparing to attend their child's wedding that weekend.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 9/11/2024 at 9:42 AM and 9/13/2024 at 3:28 PM, Resident #37 stated they asked to receive a shower prior to attending their child's wedding on 8/31/2024. They told staff they were willing to give up their normally scheduled shower on 8/27/2024 in exchange for a shower on 8/31/2024. The resident stated they were told their shower was on Tuesday and if they passed up that shower, they would have to wait until the following Tuesday to receive a shower. They received a bed bath on 8/31/2024 but felt that was not the same as a shower especially since the bed bath was given in the morning and the wedding was not until 3:00 PM. During the interview the resident was tearful and said it was hard to talk about how not having a shower affected their experience at the wedding because they did not feel clean. They stated they had clean clothes on, but their body did not feel clean. The resident did not tell their family because they would be upset, especially their parent. They said in the future they would not ask the staff for a favor when it came to their shower ever again. Every time they received a shower, they thought about the situation and how bad it made them feel.</p> <p>The 8/31/2024 facility staffing form documented four certified nurse aides and two licensed practical nurses were scheduled to work on the second floor (the resident's unit) on 8/31/2024 at 6:45 AM.</p> <p>During an interview on 9/16/2024 at 12:21 PM, Certified Nurse Aide #34 stated each resident had a weekly shower in accordance with the schedule located at the front desk. If the unit had less than four aides working on the day or evening shift, they did not give showers and would instead give a bed bath. An attempt would be made to squeeze that missed shower in prior to their next shower day. They were not working on 8/31/2024, but the plan was the resident would be showered the day before the wedding and that did not happen. It would not feel good to go to a wedding and not feel clean. It was a dignity issue that could cause feelings of sadness and depression.</p> <p>During an interview on 9/16/2024 at 2:12 PM, Licensed Practical Nurse Unit Manager #1 stated showers were given once a week. Staff should try to accommodate resident's preferences by doing such things as switching shower days with another resident. If someone missed their shower an attempt was made to do it on the following shift or day. The number of staff working did not determine if someone received a shower or not. They were not aware of Resident #37 asking for a shower on 8/31/2024, but felt they had the right to have a shower in preparation for the wedding. That was important as the resident probably saw family they had not seen in a while. If they felt unclean it was undignified and could lead to depression.</p> <p>2) Resident #137 had a diagnosis of benign prostatic hypertrophy (enlarged prostate). The 7/29/2024 Minimum Data Set documented the resident had intact cognition, had a urinary drainage device, and had no refusals of care.</p> <p>The Comprehensive Care Plan last reviewed 8/9/2024, documented the resident had a urinary drainage device related to benign prostatic hypertrophy and a sacral (lower back) wound. Interventions included urinary catheter care every shift and leg bag (a small collection bag attached underneath clothing) to be worn during daytime hours.</p> <p>The 8/12/2024 physician order documented an order to change urinary drainage device once a month and as needed and catheter care every shift.</p> <p>The following observations of Resident #137 were made:</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 9/9/2024 at 10:14 AM, walking in their room carrying their uncovered urine collection bag. The bag was visible from the hallway.</p> <p>- On 9/9/2024 at 12:51 PM, standing in the doorway of their room with their urinary catheter tubing threaded through their left pant leg and the uncovered collection bag hooked on their right pants pocket. The collection bag was visible from the hallway.</p> <p>- On 9/10/2024 at 8:33 AM, the resident had their uncovered urine collection bag hanging on their bed visible from the hallway.</p> <p>During an interview on 9/16/2024 at 12:01 PM, Certified Nurse Aide #34 stated nurse aides provided catheter care and that included changing from a leg bag to large collection bag. Blue dignity bags were used when a resident was out of bed. If someone refused a dignity bag, they reported that to the nurse as the refusals may need to be care planned. They had observed Resident #137 walking around with the collection bag hanging from their pants pocket without a dignity bag. Dignity bags were important to prevent a resident from feeling self-conscious and from feeling as though others would be judgmental towards them.</p> <p>During an interview on 9/16/2024 at 1:24 PM, Licensed Practical Nurse Unit Manager #1 stated they expected urine collection bags to be placed in a dignity bag and any refusals were reported so education and care planning would be done. Resident #137 had a catheter and they had observed the resident walking around the unit without a dignity bag. Dignity bags were important because it could cause the resident to feel bad or embarrassed.</p> <p>10NYCRR 415.5(a)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50561</p> <p>Based on observation, record review, and interview during the recertification survey conducted [DATE]-[DATE] the facility did not ensure that residents were assessed to determine their ability to safely self-administer medication, when clinically appropriate for 3 of 3 residents (Residents #38, #41, and Resident #95) reviewed. Specifically, Residents #38, #41, and #95 had prescription medications at their bedsides without physician orders for self-medication administration or resident assessments to determine their ability to safely self-administer medications. Additionally, Resident #95 had a discontinued prescription medication at their bedside.</p> <p>Findings include:</p> <p>The facility policy, Inhalers, revised ,d+[DATE], documented licensed nurses would administer inhaler medications as indicated and ordered by the physician. Inhalers were stored (labeled) in the medication cart and discarded when empty or expired.</p> <p>The facility policy, Medication/Treatment Labeling and Storage, revised ,d+[DATE] documented medications, when received in the nursing unit, would be placed in the proper storage areas, medication room, clean utility room, treatment cart or medication cart.</p> <p>The facility policy, Self-Administration of Medications, revised [DATE] documented residents had a right to be involved in all aspects of their care including self-administration of medications if the interdisciplinary team deemed it clinically appropriate. The medication would be stored in a locked drawer or locked compartment under proper temperature conditions; and the team leader would ascertain from the resident whether any routine medication(s) were self-administered and document accordingly on the electronic Medication Administration Record, generating a progress note after each self-administered medication.</p> <p>1) Resident #95 had diagnoses including chronic embolism and thrombosis (types of blood clots) of the left lower extremity. The [DATE] Minimum Data Set assessment documented the resident had intact cognition and required set-up assist for personal hygiene.</p> <p>The Comprehensive Care Plan initiated on [DATE] documented the resident had independent decision-making skills. There was no documented evidence the resident was care planned to self-administer medications.</p> <p>The [DATE] physician order documented fluticasone propionate suspension (Flonase -nasal spray) 50 micrograms, 1 spray in each nostril once a day for allergies and was discontinued (no discontinuation date documented).</p> <p>The ,d+[DATE] Medication Administration Record did not document an order for Fluticasone propionate suspension.</p> <p>The following observations were made:</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On [DATE] at 8:57 AM, a bottle of fluticasone was on the resident's bedside table. Resident #95 stated they self-administered one spray of fluticasone to each nostril most every morning for allergies.</p> <p>- On [DATE] at 11:15 AM, a bottle of fluticasone was on the resident's bedside table.</p> <p>There was no documented evidence the resident was assessed to determine their ability to safely self-administer medications.</p> <p>During an interview on [DATE] at 1:38 PM, Licensed Practical Nurse Unit Manager #1 stated a physician order and assessment was required for a resident to self-administer medications. They were not sure what the assessment consisted of or how often that assessment had to be reviewed. If a resident had a self-administration order it would show up on the medication administration record as such. It would also indicate whether the resident could keep that medication at the bedside. Medications at the bedside should have the date it was opened, and expiration dates should be checked as with any other medication. If a medication was discontinued, it should be removed from the room by whomever acknowledged the discontinuation order. Resident #95 did not have a current order for fluticasone, and they did not know why it was discontinued. If a staff member observed the fluticasone at the bedside, they should check for an active physician order and if the resident could keep the medication at the bedside. This was important because a resident that was taking a medication that was no longer prescribed could get sick and the resident could overdose themselves.</p> <p>2) Resident #41 had diagnoses including chronic obstructive pulmonary disease (lung disease). The [DATE] Minimum Data Set documented the resident had intact cognition, had bilateral upper extremity contractures, and required set-up assistance for personal hygiene.</p> <p>The Comprehensive Care Plan revised on [DATE] documented the resident had impaired pulmonary function related to chronic obstructive pulmonary disease. Interventions included administer pulmonary medications per physician order.</p> <p>The [DATE] physician order documented Combivent Aerosol ,d+[DATE] micrograms/actuation (Combivent inhaler) one puff every four hours as needed for shortness of breath. The physician order did not document the resident could self-administer or keep the medication at the bedside.</p> <p>There was no documented evidence the resident was assessed to determine their ability to safely self-administer medications.</p> <p>The following observations were made:</p> <p>- On [DATE] at 8:52 AM, an unlabeled Combivent inhaler was in a plastic container on the resident's bed.</p> <p>- On [DATE] at 12:01 PM, two unlabeled Combivent inhalers were in the top drawer of the resident's nightstand. One had an imprinted manufacturer's expiration date of ,d+[DATE].</p> <p>- On [DATE] at 1:42 PM, an unlabeled Combivent inhaler was in the resident's shirt pocket. There were two unlabeled Combivent inhalers in the top drawer of the nightstand.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On [DATE] at 10:07 AM, Licensed Practical Nurse #51 entered the resident's room during their medication administration and asked the resident where their Combivent inhaler was. The resident pulled it out of their shirt pocket and stated they had not used it yet. When Licensed Practical Nurse #51 prompted the resident to use it, the resident stated they only used it when they needed it, they did not currently need it, but would take it anyway. The resident took one puff from the inhaler. The nurse requested the resident hand over the inhaler and placed it in the medication cart.</p> <p>During an interview on [DATE] at 1:42 PM, Resident #41 stated they had carried their own inhaler for a couple of years. They used the inhaler usually once or twice during the day, once during the night, and whenever they felt short of breath. The nurses did not bring it to them. They kept their own because if they needed it, they never knew when the nurse was going to make it in to administer it to them. They did not keep track of when they used it, the nurses seldom asked if or when they had used it, and no one had watched them use the inhaler to ensure they used it properly.</p> <p>During an interview on [DATE] at 10:07 AM, Licensed Practical Nurse #51 stated residents had to be assessed before being able to self-administer medications. They thought the assessment was done by a registered nurse and could be found in the evaluation tab of the medical record. They would know if someone could self-administer medications because it would show up on the medication administration record. Inhalers at the bedside would not be locked up because the resident might need to quickly access it. It was unusual for a resident to have multiples of the same medication in their room. Resident #41 kept their Combivent at the bedside and did not have an order for the inhaler be kept at the bedside or be self-administered.</p> <p>During an interview on [DATE] at 1:38 PM, Licensed Practical Nurse Unit Manager #1 stated Resident #41's family had a history of bringing in medications including the Combivent inhaler, and they had talked to the family previously about not doing so. The resident did not have an order to have the inhaler at the bedside.</p> <p>During an interview on [DATE] at 5:03 PM, the Director of Nursing stated Resident #41 had been found with a Combivent inhaler at the bedside in the past and the family had brought them from home. The resident had used too much of the Combivent inhaler in the past and for that reason the physician had deemed it unsafe for the resident to keep medications at the bedside.</p> <p>3) Resident #38 had diagnoses including asthma, diabetes, and dysphagia (difficulty swallowing). The [DATE] Minimum Data Set assessment documented the resident was cognitively intact, required set up assistance for eating and oral hygiene, and did not reject care.</p> <p>The Comprehensive Care Plan initiated [DATE] documented the resident had impaired pulmonary (lung) function and medications were administered per orders.</p> <p>The [DATE] physician order documented Diabetic Tussin (cough syrup) oral liquid 10 milliliters by mouth twice daily for cough.</p> <p>There was no documented evidence of a self-administration assessment or a physician order for self-administration of medications.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a medication administration observation on [DATE] at 8:24 AM, Licensed Practical Nurse #24 placed Resident #38's ordered medication pills into a plastic medication cup and the Diabetic Tussin (cough syrup) oral liquid 10 milliliter was poured into another plastic medication cup. At 8:30 AM, the nurse knocked on Resident #38's door and entered the room, watched the resident take the pills and left the cough syrup on the resident's bedside tray table. The resident was eating breakfast and did not take the cough syrup.</p> <p>The ,d+[DATE] Medication Administration Record documented the resident's Diabetic Tussin was administered on [DATE] at 8:00 AM.</p> <p>During an interview on [DATE] at 9:00 AM, Resident #38 stated they liked to take their cough syrup after they had eaten breakfast. The nurses usually left the cough syrup at their bedside for them to take after breakfast.</p> <p>During an interview on [DATE] at 9:01 AM, Licensed Practical Nurse #24 stated if a medication was documented as given it meant they watched the resident ingest the medication. They did not watch Resident #38 take the cough syrup and should have to ensure they took it. They should have taken the cough syrup to the resident after breakfast when they were ready to take it. Resident required an order to self-administer medication and they did not have a self-administration of medication order.</p> <p>During an interview on [DATE] at 1:37 PM, the Assistant Director of Nursing stated if a medication was signed for on the Medication Administration Record as administered it meant the nurse watched the resident take the medications. Pre-poured medications should not be left at the bedside for safety reasons and the nurse would not know if the medication was taken if they did not watch. Resident #38 did not have an order to leave medications at their bedside or to self-administer medications. The cough syrup should not have been left at the bedside.</p> <p>During an interview on [DATE] at 5:03 PM, the Director of Nursing stated if a resident wanted to keep medications at their bedside and self-administer them, a physical and cognitive evaluation had to be done by nursing. If approved, the medication could be kept at the bedside. If not approved, there should be no medications in the room. There should not be multiples of the same medication in the room. The medication nurse should ask and ensure the resident had taken the medication as ordered.</p> <p>10NYCRR 415.3(e)(1)(vi)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448</b></p> <p>Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00314894 and NY99331169) conducted 09/9/2024-9/16/2024, the facility did not provide a safe, clean, comfortable, and homelike environment for 4 of 4 resident areas (Main Lobby, Second floor resident room [ROOM NUMBER]A, Third floor nursing station, and Third floor day room area) reviewed; and for 2 of 2 oxygen storage rooms (Third and Fourth floor oxygen storage rooms) reviewed. Specifically, there were multiple walls with peeling wallpaper and unclean floors with dust and food debris. Additionally, Resident #36's right wheelchair brake was broken and not repaired timely.</p> <p>Findings include:</p> <p>The facility policy, Daily Cleaning, dated 6/1/2000, documented the facility was cleaned daily and would be always kept clean; VCT (vinyl composition tile) flooring was dust mopped and then wet mopped with the specified cleaner; walls and doors were spot washed with a disinfectant cleaner when soiled; and all repair work must be logged in the maintenance logbook.</p> <p>The facility policy, Maintenance Electronic Work Order System, revised 12/2008, documented the facility would use an electronic work order system to better facilitate maintenance repairs/requests and to further communicate the needs of the residents with the maintenance staff. Designated facility staff would enter requests into the electronic system and maintenance would view them; maintenance would only sign off on requests when they had been addressed.</p> <p>The facility policy, Medical Equipment Management Plan, revised 7/2017 documented the goal of the facilities medical equipment management plan was to minimize the clinical and physical risks of equipment through inspection, testing, and regular maintenance and to provide education to personnel and the procedures to follow when reporting equipment problems, failures, and user errors; and the skills and/or information to perform maintenance activities.</p> <p><b>UNCLEAN, UNHOMELIKE ENVIRONMENT</b></p> <p>The following observations were made on 9/9/2024:</p> <ul style="list-style-type: none"> <li>- at 9:15 AM, the Main Lobby/receptionist area had peeling wallpaper.</li> <li>- at 10:36 AM, the housekeeping closet across from resident room [ROOM NUMBER] had an 8-inch x 3-inch hole in the wall.</li> <li>- at 11:03AM, the Fourth floor oxygen storage room had a thick layer of dust and dried debris on the floor.</li> <li>- at 11:25 AM, the Third floor day room had peeling and curling wallpaper that was falling off the walls.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- at 11:27 AM, the floors in resident room [ROOM NUMBER]A were unclean. There were yogurt containers, chocolate candy rolls, and food crumbs under the bed.</p> <p>- at 11:29 AM, the Third floor oxygen storage room had significant dust on the floor.</p> <p>- at 11:46 AM the Second floor nursing station floors were unclean and stained.</p> <p>- at 11:54 AM, the Second floor storage room next to resident room [ROOM NUMBER] had unclean and stained floors.</p> <p>During an interview on 9/12/2024 at 11:37 AM, Certified Nurse Aide #25 stated they thought housekeeping was responsible for cleaning the floors around the nursing station and resident rooms.</p> <p>During an interview on 9/12/2024 at 11:42 AM, Housekeeping Aide #39 stated they were responsible for cleaning half of the unit which included the solarium and the nursing station. Their duties included emptying trash and mopping floors. They stated maintenance was responsible for cleaning the oxygen storage closets and if floors were heavily stained Housekeeping Supervisor #47 would take care of them.</p> <p>During an interview on 9/12/2024 at 11:50 PM, Unit Secretary #50 stated the floors under the Second floor nursing station were not clean but had been mopped. They were unsure how long the floor had been unclean.</p> <p>During an interview on 9/13/2024 at 1:23 PM, Certified Nurse Aide #34 stated when areas or objects on the unit were damaged or broken, they asked Unit Secretary #50 to place a work order. They did not put work orders in themselves. They stated the resident rooms should be clean and home-like.</p> <p>During an interview on 9/13/2024 at 1:25 PM, Certified Nurse Aide #46 stated the wallpaper in the Third floor dayroom had been peeling for a while. It was not a clean and home-like environment, and they would not want their house to be in the same condition.</p> <p>During an interview on 9/16/2024 at 2:23 PM, Housekeeping Supervisor #47 stated floors were cleaned twice daily. They had problems with removing the black stains from the nursing station floors and agreed they were unclean. They had been stripping and waxing floors but fell behind in schedule. If an area or object needed repairs, staff would notify them, and they would put a work order in. They were unsure who was responsible for cleaning the oxygen storage room closets due to limited staff having keys. They had a key, but housekeeping staff did not.</p> <p><b>UNSAFE BROKEN RESIDENT EQUIPMENT</b></p> <p>Resident #36 had diagnoses including Alzheimer's disease. The 8/9/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, had upper extremity impairment on one side, used a wheelchair, and required supervision/touching assistance with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on 9/9/2024 at 2:15 PM and 9/11/24 at 11:43 AM, Resident #36 was in their room with their wheelchair on the right side of their bed. They attempted to lock the right wheel on their wheelchair, but it would not lock. They stated their right wheelchair brake had been broken for a few weeks. They had notified staff multiple times and were still waiting for maintenance to fix it.</p> <p>During an interview on 9/13/2024 at 9:30 AM, Certified Nurse Aide #25 stated Resident #36's right wheelchair brake was broken. They thought it had not worked for a few weeks. They did not notify the nurse or maintenance because they thought they were already aware it did not work.</p> <p>During an interview on 9/13/2024 at 9:50 AM, Licensed Practical Nurse #26 stated Resident #36 was alert and oriented, able to make their needs known and they used their wheelchair to get around the unit. They stated they were not aware their wheelchair did not lock, or they would have notified maintenance.</p> <p>During an interview on 9/13/2024 at 10:39 AM, Registered Nurse Supervisor #27 stated they were not aware of Resident #36's right wheelchair brake not locking. They expected staff to notify them so they could have provided the resident with another wheelchair until it was fixed.</p> <p>During interviews on 9/13/2024 at 1:20 PM and at 3:26 PM, Plant Operations Manager #29 stated housekeeping and certified nurse aides were responsible for cleaning the utility rooms. They thought housekeeping cleaned the oxygen storage room, Housekeeping Supervisor #47 had a key, but the housekeepers did not. They were not aware of Resident #36's broken wheelchair brake until they received a work order on 9/11/2024 at 2:47 PM.</p> <p>10 NYCRR 415.29(j)(1)</p>		

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NAME OF PROVIDER OR SUPPLIER  Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Riverside Dr Johnson City, NY 13790	
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>40803</p> <p>48675</p> <p>Based on observation, record review, and interviews during the recertification and abbreviated (NY00336546) surveys conducted 9/9/2024- 9/16/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 9 residents (Residents #2, #35, #37, and #64) reviewed. Specifically, Resident #2 was not provided with assistance during meals as planned; and Residents #35, #37, and #64 had unclean and untrimmed fingernails.</p> <p>Findings include:</p> <p>The facility policy, Activities of Daily Living, revised 10/2023, documented each resident would receive and the facility would provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Residents would be given the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living including hygiene, mobility, elimination, dining, and communication. Certified nurse aides would follow the Kardex (resident care instructions) and if the resident refused care or had a change in condition requiring a level of care different from the Kardex, they would alert the licensed nurse or nurse supervisor.</p> <p>The facility policy, Nail Care, revised 10/2011, documented the purpose of nail care was to ensure cleanliness and to prevent infection. Routine nail care was to be done following a bath or shower, and whenever possible. Fingernails of residents who were diabetic were to be trimmed by a licensed nurse.</p> <p>1) Resident #2 had diagnoses including Alzheimer's disease, dysarthria (difficulty speaking), and feeding difficulties. The 8/21/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment and required moderate assistance with eating (receives some assistance in getting food to their mouth).</p> <p>The Comprehensive Care Plan initiated 3/1/2022 and revised on 8/22/2024, documented a risk for alteration in nutrition related to a self-performance deficit, high blood pressure, weight loss and diabetes mellitus. Interventions included moderate assistance with feeding when in bed, supervision assistance when in their wheelchair, positioned with peers in common area or dining room, and adaptive equipment and straws with meals.</p> <p>The 6/10/2024 Registered Dietitian #4 progress note documented Resident #2 required 1730 kilocalories and 68 grams of protein per kilogram per day.</p> <p>The 7/30/2024 Nurse Practitioner #42 progress note documented they recommended to increase the resident's protein for wound healing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 9/16/2024 Kardex documented the resident required adaptive equipment at meals including cups with lids and straws and a divided plate; moderate assistance for eating when in bed; supervision assistance for eating when in their wheelchair and provide verbal cues and encouragement.</p> <p>During an observation on 9/9/2024 at 1:07 PM, Resident #2 was served their lunch meal of stuffed shells, spinach, and a dinner roll on a divided plate; and vanilla ice cream, a Health Shake (nutritional supplement), a brownie, 2 orange juices, diet cola, water, and yogurt. The meal ticket documented the resident required moderate assistance with meals. At 1:13 PM, Resident #2 was provided their meal with cups and lids placed by staff. The staff did not provide further assistance with the meal. At 1:26 PM, Resident #2 had eaten 5% of the stuffed shells, 0-25% of the spinach, 0% of the roll, 0% of the yogurt. 100% of the brownie, 0% of the ice cream, 75% of the orange juice, and 25% of Health Shake. At 1:34 PM, Resident #2 was eating their stuffed shells with their fingers and by 1:40 PM had eaten all the stuffed shells.</p> <p>During an observation on 9/11/2024 at 12:48 PM, Resident #2 was served their lunch in the dining room which included macaroni and cheese, salad, Health Shake, yogurt, water, Magic Cup (frozen nutritional supplement), cola, milk, and orange juice. At 12:59 PM, Resident #2 was eating by themselves holding their fork with both hands and bringing one noodle to their mouth. There was no staff assisting the resident. At 1:21 PM, the resident had not received any feeding assistance from staff. At 1:30 PM, the resident was attempting to eat their Magic Cup with a fork. They set the fork on the napkin and attempted to bring the fork to their mouth.</p> <p>During an interview on 9/16/2024 at 11:16 AM, Certified Nurse Aide #48 stated they reviewed the care plan to know the level of assistance required for each resident including eating assistance. They were familiar with Resident #2 and stated they were independent with eating and could pick up cups and utensils on their own. They stated if a resident's care plan documented they required moderate assistance with eating that meant the resident required cueing only.</p> <p>During an interview on 9/16/2024 at 11:20 AM, Licensed Practical Nurse #32 stated staff reviewed the care plan daily to determine the level of assistance required for care. The resident's level of assistance with feeding recently changed and they now required maximum assistance with eating. They stated if the care plan documented moderate assistance with eating, the resident required assistance with eating and staff should sit with them at all meals.</p> <p>During an interview on 9/16/2024 at 11:28 AM, Director of Therapy #49 stated the therapist determined how much assistance a resident needed for eating after completing an evaluation. This was documented on the care plan. They stated Resident #2 required assistance with eating and staff should sit with the resident and assist with feeding as necessary.</p> <p>2) Resident #37 had a diagnoses including osteoarthritis and muscle weakness The 8/22/2024 Minimum Data Set assessment documented the resident was cognitively intact; was dependent for personal hygiene and required substantial assistance with bathing.</p> <p>The Comprehensive Care Plan initiated 3/1/2022 and revised 8/31/2024, documented a self-care personal hygiene performance deficit related to activity intolerance, limited mobility, and limited range of motion. Interventions included nail care on bath day and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 9/16/2024 Kardex (care instructions) documented maximum assistance with personal hygiene and nail care on bath day and/or as needed.</p> <p>The 8/12/2024 physician order documented weekly skin and nail monitoring every day shift every Tuesday for skin integrity/hygiene.</p> <p>The undated second-floor shower schedule documented Resident #37's weekly showers were scheduled for Tuesdays on the day shift.</p> <p>The following observations of Resident #37 were made:</p> <ul style="list-style-type: none"> <li>- On 9/9/2024 at 2:24 PM, fingernails were long and jagged.</li> <li>- On 9/13/2024 at 8:41 AM, fingernails were long and jagged with brown debris under the right thumb and index fingers.</li> </ul> <p>During an interview on 9/9/2024 at 2:24 PM, Resident #37 stated their nails were too long and they preferred them short. They were told they would be cut the prior weekend, but they were not.</p> <p>During an interview on 9/16/2024 at 12:21 PM, Certified Nurse Aide #34 stated aides could perform nail care. Nails were supposed to be checked on shower days, but dirty nails should be taken care of anytime they were noticed. Well-groomed fingernails were important for dignity. Infections could develop if the resident scratched themselves. If someone needed nail care and they refused, they would tell the nurse. They had noticed Resident #37's fingernails were long and needed attention. The resident would let them cut their fingernails.</p> <p>During an interview on 9/16/24 at 2:12 PM, Licensed Practical Nurse Unit Manager #1 stated nail care should be done on shower days and anytime in between if needed. Certified nurse aides could do fingernail care. Resident #37 did not refuse care. Nail care was important because long, dirty nails could cause scratches which could lead to infection, and it was undignified have dirty nails.</p> <p>3) Resident #35 had diagnoses including Alzheimer's disease, stroke, and diabetes. The 9/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, required supervision or touching assistance with personal hygiene, eating, oral hygiene, shower/bathing, and dressing.</p> <p>The Comprehensive Care Plan initiated 6/21/2024 documented the resident had self-care performance deficit with personal hygiene related to a stroke. Interventions included supervision and diabetic nail care by nurse and/or podiatrist (specializes in foot care).</p> <p>The 9/13/2024 Kardex (care instructions) documented the resident required diabetic nail care by nurse or podiatrist.</p> <p>The following observations of Resident #35 were made:</p> <ul style="list-style-type: none"> <li>- On 9/9/2024 at 12:34 PM, in their room with long, unkept fingernails with black/brown debris under the nails. The resident stated their nails were too long, they got in the way, and staff did not trim their fingernails when they asked.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 9/10/2024 at 9:15 AM, in their room with long, unkept fingernails with black/brown debris under the nails.</p> <p>- On 9/11/2024 at 10:06 AM, in their room with long, unkept fingernails with black/brown debris under the nails.</p> <p>During an interview on 9/13/2024 at 9:32 AM, Certified Nurse Aide #25 stated personal hygiene consisted of hair care, oral care, nail care, and bathing. They had noticed Resident #35's long nails, but certified nurse aides could not trim them because the resident was a diabetic. The nurses were responsible for trimming Resident #35's nails for safety reasons. They stated it was important for the resident's nails to be clean and trimmed to prevent them from cutting themselves or getting an infection.</p> <p>During an interview on 9/13/2024 at 9:38 AM, Licensed Practical Nurse #26 stated the certified nurse aides were responsible for residents' personal hygiene but were not able to trim nails if the resident was a diabetic. They stated Resident #35 never refused care, and they had never cut the resident's nails. They thought it should have been listed on the treatment administration record to remind nurses the resident was a diabetic that required nail trimming, or they would just assume the certified nurse aides were going to do it. They stated it was important for the resident to have clean and trimmed nails to prevent cuts and wounds from developing, and for the resident's dignity.</p> <p>During an interview on 9/13/2024 at 10:41 AM, Registered Nurse Supervisor #27 stated certified nurse aides were responsible for resident's nail care but if the resident was a diabetic the licensed nurse was responsible for trimming them. They stated Resident #35's nails should have been checked daily during care and by the nurse during their weekly skin check. They stated it was important for the resident's nails to be clean and trimmed to prevent them from scratching themselves or others which could lead to infection.</p> <p>10NYCRR 415.12(a)(3).</p> <p>50561</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49448</p> <p>Provide activities to meet all resident's needs.</p> <p>Based on observation, record review, and interview during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 2 residents (Resident #5) reviewed. Specifically, Resident #5 was not offered meaningful activities that included their interests and preferences.</p> <p>Findings include:</p> <p>The facility policy, Activity Department Programming, effective 1/1/2000, documented the activities department provided activities programs seven days a week and included individual, group, and independent activities. A visitation program designated to reach residents who would not or could not attend other activities was included. Activities reflected the interests listed on the initial assessment form.</p> <p>Resident #5 had diagnoses of bipolar disorder (a type of mental illness), depression, and spinal stenosis (narrowing of the spinal) of the lumbar (lower back) and thoracic (middle back) regions. The 2/22/2024 Minimum Data Set assessment documented the resident was cognitively intact, they felt down or depressed several days, and they felt it was very important to have books, newspapers, and magazines to read, listening to music, and going outside when weather permitted.</p> <p>The Comprehensive Care Plan initiated 4/12/2023 documented leisure time activities of one-on-one visits to reminisce and talk about interests, self-selected daily activities of interest that included reading, watching television, and crocheting in their room.</p> <p>The 2/23/2024 Quarterly Activities Evaluation completed by Activities Director #20 documented the resident did not attend activities but enjoyed one-on-one visits, snack/ beverage carts, crocheting, reading, word searches, visiting with family, and watching television.</p> <p>The 7/1/2024 Quarterly Activities Evaluation completed by Activities Director #20 documented the resident did not attend activities but enjoyed pet therapy visits, one-on-one visits, specialty carts, visiting with family, knitting, and watching television.</p> <p>The 9/4/2024 progress note by Activities Director #20 documented the resident did not attend group activities. The resident preferred their room and privacy and accepted one-on-one visits by staff and visitors. They would benefit from socialization and would continue to encourage the resident to participate in activities that interested them.</p> <p>The September 2024 activity calendar documented the following daily activities:</p> <p>- On 9/9/2024 at 10:30 AM Who am I?, at 1:00 PM one-on-one visits, at 2:30 PM crafty hour, at 3:30 PM cornhole and at 4:30 PM Bingo.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 9/10/2024 at 10:30 AM Travel to Colorado, at 3:30 PM baking club, at 4:30 PM noodle ball, and at 6:00 PM movie and popcorn.</p> <p>- On 9/11/2024 at 10:30 AM True or False, at 1:30 PM resident council, at 2:30 PM pet therapy visits, at 3:00 PM trivia, at 4:00 PM ice cream cart, at 6:00 PM chair exercises, and at 7:00 PM noodle ball.</p> <p>- On 9/12/2024 at 10:30 AM bingo, at 2:00 PM Catholic mass, at 3:00 PM chocolate milkshake social, at 4:00 PM relax and color, and at 6:00 PM movie and popcorn.</p> <p>- On 9/13/2024 at 10:30 AM trivia, at 1:00 PM one-on-one visits, at 2:00 PM chair exercises, at 3:00 PM bingo, and at 4:30 PM happy hour.</p> <p>The resident's activity attendance records from June 2024- September 2024 did not document the resident attended or was provided with any activities.</p> <p>There was no documented evidence in the activity progress notes of one-on-one visits with the resident since November 2023.</p> <p>During observations on 9/9/2024 at 11:08 AM and 9/10/2024 at 3:23 PM, the resident was observed lying on their back asleep in their bed wearing a hospital gown.</p> <p>During an observation and interview on 9/11/2024 at 9:44 AM, Resident #5 was lying on their back in bed dressed in a hospital gown. They stated they did not like to socialize in a group. They had problems with depression, and enjoyed one-on-one visits, but they only had them one to three times per year. They wanted to have a one-on-one visit once per week and thought it would help their mood. They also enjoyed reading and completing the word puzzle in the daily chronicle. There were no books observed in their room.</p> <p>During an observation and interview on 9/12/2024 at 12:44 PM, the resident was sitting up in bed in a hospital gown working on a word puzzle. The resident stated they enjoyed mystery books and there were no books observed in their room.</p> <p>During an interview on 9/13/2024 at 9:33 AM, Activities Aide #22 stated they documented in the progress notes any activity that was completed. One-on-one visits were done every day with the residents who did not like to attend group activities. Residents that did not want to socialize deserved the same care and respect. Resident #5 enjoyed one-on-one visits and enjoyed reading. They had not provided any books to the resident, but the activities department should have provided books. It was important the resident had reading material and had one-on-one visits for quality of life and for social interaction. Resident #5 was always in their bed, and they often said hello to them when they were going to get their roommate for activities.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/13/2024 at 9:45 AM, Activity Director #20 stated resident's preferences were in their quarterly assessments and carried over to the care plan. Residents who did not attend activities should be provided with one-on-one visits at least weekly. They did not believe Resident #5 liked to read but they provided books to other residents that liked to read. The resident did not like to participate in activities and did get one-on-one visits but sometimes refused them. It was documented in a progress note if a one-to-one visit was completed or refused. They were not sure how long it had been since the resident had a one-on-one visit, but the visits were important for social interaction. The resident enjoyed talking about crocheting. They were responsible for the quarterly assessments and preferences were updated on the care plan.</p> <p>10NYCRR 415.5(f)(1)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40803</p> <p>.</p> <p>49448</p> <p>Based on observation, record review, and interview during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 4 residents (Resident #120) reviewed. Specifically, Resident #120's physician ordered urinalysis (a laboratory test that examines urine for a variety of conditions) was not obtained timely.</p> <p>Findings include:</p> <p>The facility policy, Radiology and Other Diagnostic Services, revised 11/2016, documented the facility would provide or obtain diagnostic services to meet the needs of its residents pursuant to an order by an appropriate practitioner. The facility was responsible for the quality and timeliness of such services.</p> <p>Resident #120 had diagnoses of unspecified dementia, cerebral infarction (stroke), and hypothyroidism. The 7/10/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was incontinent of bladder and bowel, did not have a urinary catheter, and did not have a urinary tract infection in the last 30 days.</p> <p>The Comprehensive Care Plan initiated 1/24/2024 and revised 6/10/2024 documented an alteration in bladder function due to dementia. Interventions included bladder scans and straight catheter as ordered; toilet per request, incontinence care/toileting when resident was restless; incontinence care as needed; incontinence briefs medium pull-ups during day and medium briefs at night; monitor for signs and symptoms of urinary tract infection.</p> <p>The 8/15/2024 physician order documented bladder scan every shift and straight cath (inserting a tube into the urinary tract to obtain a urine specimen) if greater than 250 milliliters for bladder distention for 3 days.</p> <p>An 8/29/2024 Physician #54 progress note documented they were asked to follow up with the resident to assess a urinalysis. Lab data was reviewed with nursing, but a urinalysis result could not be found. They were unsure if the resident's urinalysis was drawn or if they just did not have access to the results. An order was placed to do a urinalysis with microscopy with a reflex for culture.</p> <p>The 8/29/2024 physician order documented urinalysis with microscopy (using a microscope) and reflex for culture (checks for bacteria in the urine).</p> <p>There were no nursing notes documenting an order for a urinalysis and culture, or if the resident had a urine sample collected.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There were no documented laboratory results for a urinalysis or culture.</p> <p>During an interview on 9/13/2024 at 12:10 PM, Registered Nurse #52 stated if a verbal order was given for a lab, the order should be placed in the computer. The lab sheet was printed and placed with the specimen. The lab order was also placed on the 24-hour report. Lab results were faxed to the unit and the Supervisor was called with abnormal results.</p> <p>During an interview on 9/16/2024 at 12:17 PM, the Assistant Director of Nursing stated urinalysis orders could be entered into the computer by any nurse and placed on report in the electronic medical record software. They did not see that Resident #120's urine was collected for a urinalysis. It was important to follow physician orders. They stated Physician #54 ordered the urinalysis to be collected and it was not completed timely.</p> <p>During an interview on 9/16/2024 at 3:56 PM, the Director of Nursing stated urinalysis orders were faxed to the lab and the urine specimen was collected and sent to be processed. If a urinalysis could not be completed, the licensed practical nurse should have documented the reason why it was not obtained and medical should have been notified. It was important to obtain a urinalysis to follow up on the results; the urinalysis was missed and should have been completed.</p> <p>During an interview on 9/13/2024 at 1:27 PM, Physician #54 stated they had filled in at the facility for three days and wrote Resident #120's order for a urinalysis. When they wrote orders, they also placed them on a calendar for Physician #19 to follow up on. Physician #54 stated they assigned the follow-up back to Physician #19 due to not seeing the results. It was important for a urinalysis to be obtained timely so treatment could be started if there was a urinary tract infection. Nursing should document if a urinalysis could not be obtained and notify medical so new orders could be placed.</p> <p>10NYCRR 415.12</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>40803</p> <p>Based on record review and interviews during the recertification and abbreviated (NY00350839) surveys conducted 9/9/2024-9/16/2024, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for 2 of 6 residents (Residents #88 and #195) reviewed. Specifically, Resident #88's wound treatments were not consistently documented as completed; and Resident #195 developed impaired skin integrity on the sacrum (the triangular bone at the base of the spine) that was not assessed by a qualified professional to determine interventions and routine monitoring, and treatments were not consistently applied as ordered. Subsequently, the area progressed to a Stage 4 (full thickness skin loss exposing muscle, bone, or tendon) pressure ulcer and the resident developed sepsis requiring hospitalization . This resulted in actual harm to Resident #195 that was not immediate jeopardy.</p> <p>Findings include:</p> <p>The facility policy, Documentation of Pressure Ulcer and Chronic Wounds, revised 6/2023 documented pressure ulcers and chronic wounds were monitored closely to monitor effectiveness of treatment and change in risk factors. An ongoing inspection and assessment of all pressure sores and chronic wounds would be conducted weekly and as needed. The Assistant Director of Nursing was responsible for initiating weekly skin status evaluations when a pressure ulcer, stasis wound, or chronic wound was identified. The provider would be updated on new skin issues and/or change in condition. The Assistant Director of Nursing or designee were responsible for weekly evaluations which included, type, site, stage, size, description/characteristics, treatment, debridement (removal of dead tissue), exudate (drainage), pain management, and progress toward healing.</p> <p>The facility policy, Dressing-Clean Technique, revised 12/2007, documented the treatment was performed by a licensed nurse following a physician order or house treatment. The treatment would be completed, and the nurse was to initial the treatment sheet and document changes as needed.</p> <p>1) Resident #195 had diagnoses including a hip fracture and chronic kidney disease. The 4/27/2022 Admission Minimum Data Set assessment (a health screening tool) documented the resident had moderately impaired cognition, required extensive assistance with bed mobility and transfers, was at risk of developing pressure ulcers, had no unhealed pressure ulcers, and had moisture associated skin damage (skin impairment caused by excessive moisture).</p> <p>The 4/21/2022 physician order documented Calmoseptine (protective barrier cream) to buttocks twice daily with incontinence care; licensed nurse weekly skin checks and report any new skin issues to the registered nurse for assessment.</p> <p>The 5/6/2022 at 1:39 PM Licensed Practical Nurse #1 progress note documented the resident had an open area to their buttock and Assistant Director of Nursing #11 was made aware. A new order was obtained to cleanse the buttock with normal saline, apply Medihoney (medicinal honey used as a wound treatment), cover with a dry dressing, and change every other day.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Riverside Dr Johnson City, NY 13790	
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F 0686  Level of Harm - Actual harm  Residents Affected - Few	<p>The 5/6/2022 physician order documented to cleanse open area to buttocks, apply Medihoney, and cover with dry dressing every other day until healed.</p> <p>There was no documented evidence the wound was assessed by a qualified professional. There was no corresponding progress note by former Assistant Director of Nursing #11.</p> <p>The 5/11/2022 at 10:37 PM Licensed Practical Nurse #2 progress note documented the resident was noted with an open area and they reported their findings to the Registered Nurse Supervisor.</p> <p>The 5/12/2022 at 1:22 AM Registered Nurse Supervisor #3 progress note documented the resident had 2 right buttocks wounds that measured 3.8 centimeters x 1.5 centimeters, and 1.9 centimeters x 1.7 centimeters; and a left buttock wound that measured 1.8 centimeters x 1.5 centimeters (no depth recorded for any of the areas). The areas had bloody drainage, they were cleansed, and a protective dressing was applied. Nursing was to update the primary care provider in the morning.</p> <p>There was no documented evidence the medical provider was notified of the buttock wounds.</p> <p>There were no documented wound assessments in the nursing progress notes from 5/13/2022-6/15/2022.</p> <p>The 6/2022 Treatment Administration Record documented:</p> <ul style="list-style-type: none"> <li>- cleanse open area to buttock with normal saline, apply Medihoney, cover with dry dressing, change every other day, and as needed until healed one time a day every other day with a start date of 5/6/2022 and a discontinue date of 6/10/2022. There was no documentation the treatment was completed on 6/2/2022 and 6/6/2022.</li> <li>- cleanse open areas to buttock with normal saline, apply Medihoney, cover with a dry dressing, change every day as needed until healed one time a day every other day with a start date of 6/10/2022 and a discontinue date of 6/17/2022 (same as previous order). There was no documented evidence the treatment was completed on 6/12/2022 and 6/14/2022.</li> </ul> <p>The 6/16/2022 at 2:19 PM Physical Therapist #5 progress note documented the resident's family expressed concern about a wound on the resident's buttock and requested a wound care appointment at the hospital. Therapy provided the resident with a wedge cushion for offloading the wound. The resident had no ROHO (specialized air-filled wheelchair cushion to reduce pressure injury and provide skin protection) at the present time for pressure reduction. The Comprehensive Care Plan was updated to reflect a wedge cushion.</p> <p>The 6/16/2022 at 4:44 PM Registered Nurse Unit Manager #6 progress note documented the resident had an unstageable (a pressure ulcer where the wound bed was obscured by non-viable tissue) pressure ulcer on their coccyx (tailbone) that was 6 centimeters x 3 centimeters x 1.5 centimeters with 0.3 centimeters of undermining (wound edges separate from surrounding healthy tissue creating a pocket). Slough (tan/grey non-viable tissue) was noted with moderate serosanguinous (combination of blood and serum, the clear part of blood) and odor (possible indication of infection). The resident stated they had frequent pain in the area. The area was cleansed and dressed, and a wound care consult was ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan initiated 6/16/2022 documented the resident had a skin related injury of an unstageable wound to the coccyx. Interventions included monitor skin for changes daily during care, and treatment per physician order.</p> <p>The 6/16/2022 Nurse Practitioner #7 progress note documented nursing staff had concerns of a sacral wound which was not present during the last routine examination (5/19/2022). The resident reported pain at the wound site and required oral narcotics for pain. The wound was assessed as a large unstageable sacral ulcer with odor and sloughing eschar (brown/black non-viable tissue). Wound care orders were in place. The plan was an immediate referral to outpatient wound care, and nursing staff were to continue twice a day wound dressing changes.</p> <p>There was no documented evidence of twice a day wound dressing changes for the resident. The last physician orders were from 5/6/2022 and documented to cleanse open areas to buttock, apply Medihoney, and cover with dry dressing every other day until healed.</p> <p>Physician orders documented :</p> <ul style="list-style-type: none"> <li>- on 6/16/2022, to buttock open area cleanse with normal saline, sterile wet to dry inside wound, Aquacel (absorbent dressing) to excoriated areas, cover with Opticell two times a day for wound care.</li> <li>- on 6/17/2022, clean open areas to buttock with normal saline, apply Medihoney, cover with dry dressing and change every other day and as needed until healed.</li> </ul> <p>There was no physician order discontinuing the 6/16/2022 treatment or documentation as to why the treatment was changed back to every other day from twice daily.</p> <p>The 6/2022 Treatment Administration Record documented:</p> <ul style="list-style-type: none"> <li>- cleanse open area to buttock with normal saline. Apply Medihoney, cover with dry dressing, change every other day, and as needed until healed, one time a day every other day with a start date of 6/17/2022.</li> <li>- to buttock open area cleanse with normal saline, sterile wet to dry inside wound, Aquacel to excoriated areas, cover with Opticell two times a day for wound care with a start date of 6/16/2022 and a discontinue date of 6/17/2022.</li> </ul> <p>The 6/17/2022 at 7:34 AM Physical Therapist #5 note documented the resident was provided an alternating air mattress (a specialty mattress for pressure reduction) on 6/16/2022.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 6/23/2022 Wound Care Consultant Nurse Practitioner #9 documented the resident's family member was visiting when the resident complained of buttock pain and upon further examination, the family member realized the resident had a large opening in the sacral area. The family notified nursing who was not aware of the wound. Today, the Stage 4 pressure ulcer had moderate serosanguinous drainage without odor. There was a rash like excoriation (scraped) surrounding the wound with a small opening on the left buttock. The wound was 8 centimeters x 8 centimeters x 1.8 centimeters with undermining between 8 to 10 o'clock that was 0.9 centimeters. The wound was mostly covered in eschar and slough which was debrided (removal of dead tissue using a scalpel). Recommendations included Medihoney to wound bed and cover with foam border dressing daily. Cover left buttock excoriation with Xeroform (petroleum-based treatment) and foam dressing daily. Follow up in 1 week.</p> <p>The 6/24/2022 physician order documented cleanse coccyx wound with soap and water, Medihoney to wound base, Xeroform to left buttock and cover with foam bordered dressing daily.</p> <p>The 6/2022 Treatment Administration Record documented to wound on coccyx cleanse with soap and water, Medihoney to sacral base, Xeroform to left buttock, cover with foam border, skin prep to peri-wound (skin surrounding wound), Calmoseptine to red areas after foam applied with a start date of 6/23/2022 and a discontinue date of 7/3/2022. On 6/29/2022 and 6/30/2022 Licensed Practical Nurse #12 documented 9 other/see progress note. There were no associated progress notes by Licensed Practical Nurse #12.</p> <p>The 7/1/2022 Wound Care Consultant Nurse Practitioner #9 documented the resident's Stage 4 pressure ulcer was 8 centimeters x 7.8 centimeters x 1.8 centimeters and the wound continued to make minimal progress. The note documented to switch from Medihoney to Hydrofera Blue (antibacterial wound treatment) and cover the larger excoriation on the right buttocks with Xeroform and foam border and finish with Calmoseptine (protective treatment) to exposed red areas. Advised little to no wheelchair time and spend most time in bed with turning and positioning.</p> <p>The 7/7/2022 at 5:26 PM Registered Nurse #10 progress note documented the resident was sent to the hospital from their wound care appointment.</p> <p>There was no documented evidence of a wound care appointment for 7/7/2024 in the resident's record.</p> <p>The 7/8/2022 at 5:31 AM Registered Nurse #13 progress note documented the resident was admitted to the hospital for sacral osteomyelitis (infection of the bone), a surgical consult was to be obtained, and the Wound Clinic was unable to debride the wound without going to the bone.</p> <p>The 7/13/2022 hospital discharge summary documented a discharge diagnosis of sepsis secondary to an infected sacral ulcer. The resident was treated by an outside wound consultant and at their 7/7/2022 wound appointment, the resident's wound was noted with odor and drainage and the resident was sent to the hospital. At the hospital, the resident was found with a large infected sacral ulcer with foul odor, exposed bone and surrounding necrotic (dead) tissue. Debridement was done by surgery and the resident had a wound vacuum assisted closure device applied (a treatment that uses suction to help heal wounds).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 8/22/2024 at 11:41 AM, Licensed Practical Nurse #1 stated when a resident was found with a new wound, they were supposed to let the charge nurse and wound nurse know and have a registered nurse assess the area. On 5/6/2022, they recalled the resident's wound was superficial with some missing skin and they notified the former Assistant Director of Nursing #11 for assessment. They believed Assistant Director of Nursing #11 assessed the resident's wound that day though was not sure why a note was not written.</p> <p>On 8/22/2024 at 11:41 AM and 8/23/2024 at 10:17 AM, former Assistant Director of Nursing #11 was unable to be reached for an interview.</p> <p>On 8/22/2024 at 12:17 PM and 8/23/2024 at 10:18 AM, Registered Nurse #6 was unable to be reached for an interview.</p> <p>During an interview on 9/4/2024 at 8:20 AM and on 9/9/2024 at 8:07 AM, the Director of Nursing stated a registered nurse needed to assess skin after staff found an impairment. They expected an assessment to be completed within a couple of hours so the physician could be notified, and a treatment ordered. They expected the care plan to be reviewed at that time. Pressure ulcers, skin with moisture issues, and skin tears were tracked weekly because they could see changes to skin from week to week and keep dietary and therapy involved with changes. They expected treatments to be signed for when completed. On 5/6/2022, they expected a registered nurse assessment. In 2022, assessments were done on paper, and they were not able to find documentation if an assessment was done. They stated the resident's care plan should have been reviewed on 5/6/2022 and the resident's wound should have been tracked weekly. They expected the physician would have been notified on 5/16/2022 of the resident's new skin impairments and expected the care plan to have been reviewed. On 6/2/2022, 6/6/2022, 6/12/2022, and 6/14/2022, when treatments were not signed on the Treatment Administration Record, that meant either the treatment was not completed, or staff forgot to sign they completed the treatment.</p> <p>During a telephone interview on 9/4/2024 at 10:16 AM and on 9/9/2024 at 8:28 AM, the facility's current Medical Director stated when a resident was found with impaired skin integrity, the wound nurse and wound provider should be notified. The Medical Director stated they wanted to be notified the same day if a wound was worsening or had become infected. They expected resident wounds to be monitored at the time of the dressing change and if changes were noted, the wound nurse or registered nurse should be notified for assessment. They expected treatments to be completed as ordered.</p> <p>2) Resident #88 had diagnoses including Alzheimer's disease, depression, and age-related physical debility. The 7/24/2024 Minimum Data Set assessment (a health screen tool) documented the resident had severely impaired cognition, did not reject care, had both upper and lower extremity impairments, required substantial/maximal assistance with rolling left and right, had 1 Stage 3 pressure ulcer (full thickness tissue loss) that was not present on admission.</p> <p>The 2/15/2024 physician orders documented to apply Prevalon boots (a cushioned pressure relief device placed on the foot) to bilateral feet or skin protection every shift.</p> <p>The revised 5/10/2024 Comprehensive Care Plan documented the resident had a pressure ulcer on the left plantar (bottom) foot. Interventions included administer treatments as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 8/20/2024 physician orders documented to cleanse the left plantar foot with 1/4 strength Dakins (antimicrobial solution), paint the outside of the wound with betadine (antiseptic), pack wound base with betadine soaked gauze, and cover with a dry dressing twice daily and as needed when soiled.</p> <p>The 9/2024 Treatment Administration Record documented to cleanse the left plantar foot with 1/4 strength Dakins, paint the outside of the wound with betadine, pack wound base with betadine soaked gauze, and cover with a dry dressing twice daily and as needed when soiled with a start date of 8/20/2024.</p> <p>There was no documented evidence the treatment was completed as ordered on the 9/7/2024 7:00 AM - 3:00 PM shift, and on 9/8/2024 for both the 7:00 AM - 3:00 PM and 3:00 PM -11:00 PM shifts.</p> <p>The 9/2024 Treatment Administration Record documented Licensed Practical Nurse #31 applied Prevalon boots to the resident on 9/7/2024 during the 7:00 AM - 3:00 PM shift, and on 9/8/2024 during the 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM shifts.</p> <p>During an interview on 9/12/2024 at 1:25 PM Licensed Practical Nurse #32 stated if a resident had a treatment order the nurse should document the treatment was completed as ordered. If they were unable to complete the treatment, they should document in a progress note and let the Nursing Supervisor know. If staff did not document the treatment was completed it was assumed the treatment was not completed. If they observed a resident without their ordered treatment completed, they would document their findings and let the Nursing Supervisor know. Treatments should be completed as ordered to aid with wound healing.</p> <p>During an interview on 9/12/2024 at 2:52 PM, Licensed Practical Nurse #31 stated they worked both the 7:00 AM - 3:00 PM and 3:00- 11:00 PM shifts on 9/7/2024 and 9/8/2024 on the 4th floor. A treatment order should be listed on the Treatment Administration Record. When they completed the treatment, they should sign that it was done. If the resident refused or they were unable to complete the treatment as ordered, they should document a progress note and let the Nursing Supervisor know. If the treatment was not signed as completed it was assumed the treatment was not done. It was important to complete the wound treatments as ordered to aid with wound healing. They stated Resident #88 could be combative with care, but they would reapproach the resident when they were. They stated they did not recall not being able to complete the resident's dressing changes on 9/7/2024 and 9/8/2024. If they were unable to do so they would have let the Nursing Supervisor know and write a note.</p> <p>During an interview on 9/16/24 at 12:17 PM the Assistant Director of Nursing stated treatments should be completed as ordered and signed for in the medical record. If a nurse was unable to complete the treatment due to a resident refusal or other issues, they should notify the Nursing Supervisor and document in a progress note. It was important to complete treatments to aid with wound healing. If a nurse did not document the treatment was completed it meant the treatment was not done.</p> <p>10 NYCRR 415.12(c)(2)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>40803</p> <p>Based on record review and interview during the recertification and abbreviated (NY00350839 and NY00331169) surveys conducted 9/9/2024-9/16/2024, the facility did not ensure maintenance of acceptable parameters of nutritional status for 3 of 4 residents (Residents #2, #88, and #195) reviewed. Specifically, Residents #2, #88, and #195 developed pressure ulcers and their nutritional needs were not reassessed timely to accommodate increased requirements for wound healing.</p> <p>Findings include:</p> <p>The facility policy, Nutritional Screen/Assessment, revised 5/2017, documented the dietetic technician and registered dietitian were responsible for nutritional screening, assessment, setting of measurable goals and implementing the nutritional plan of care to obtain the resident's optimal nutritional status. The screening included but was not limited to skin intervention as indicated. The resident would be continually assessed, and findings were documented in the dietary progress notes and nutritional care plan. Estimated needs were documented as 30 - 35 calories/ kilograms of body weight for pressure sore healing, 1.2 grams - 1.5 grams of protein for pressure ulcers and 25 milliliters to 30 milliliters of fluid for the elderly.</p> <p>1) Resident #195 had diagnoses including a hip fracture and chronic kidney disease. The 4/27/2022 Admission Minimum Data Set assessment documented the resident had moderately impaired cognition, required supervision with set up help for eating, was at risk of developing pressure ulcers, weighed 168 pounds, had no unhealed pressure ulcers, and had moisture associated skin damage (skin impairment caused by excessive moisture).</p> <p>The 4/22/2022 physician order documented a regular diet, mechanical soft (easy to chew) texture, and regular liquid consistency.</p> <p>The 4/26/2022 Registered Dietitian #4 Dietary/Nutritional Screen documented the resident required 1300 calories and 52 grams of protein (0.8 grams of protein per kilogram of body weight) per day. The resident had intact skin with a surgical incision, received a regular consistency diet, and had variable intakes consuming 50-75% of meals, with some 25-75%. The plan was to encourage intake and follow up as needed.</p> <p>The 5/6/2022 at 1:39 PM Licensed Practical Nurse #1 progress note documented the resident had an open area to their buttock and the Assistant Director of Nursing was made aware.</p> <p>The 5/12/2022 at 1:22 AM Registered Nurse Supervisor #3 progress note documented the resident had right buttocks wounds that measured 3.8 centimeters x 1.5 centimeters, and 1.9 centimeters x 1.7 centimeters; and a left buttock wound that measured 1.8 centimeters x 1.5 centimeters (no depth recorded for any of the areas). The areas had bloody drainage, they were cleansed, and a protective dressing was applied. Nursing was to update the primary care provider in the morning. There was no documented evidence the resident's provider was notified of the skin impairments.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 5/16/2022 at 1:25 PM Registered Dietitian #4 progress note documented they were made aware of a wound on the resident's buttocks. The resident was consuming 75-100% meals and intakes were adequate to improve wound status and maintain weight. The plan was to trial Ensure Clear (dietary supplement) at breakfast. There was no documented evidence the resident's nutritional status was reassessed timely when the resident developed multiple wounds 10 days prior, or that the resident's protein and calorie needs were reassessed to accommodate increased needs for wound healing.</p> <p>The Comprehensive Care Plan initiated 4/21/2022 documented the resident was at risk for alterations in nutrition related to impaired skin integrity. Interventions included a regular diet, mechanical soft consistency. On 5/16/2022 supplements on meal trays; Ensure Clear at breakfast was added as an intervention.</p> <p>The 6/7/2022 at 4:27 PM Registered Dietitian #4 progress note documented the resident had no reported skin breakdown and Ensure Clear would be discontinued. There was no documentation in the resident's medical record their skin impairment was healed.</p> <p>The 6/16/2022 at 4:44 PM Registered Nurse Unit Manager #6 progress note documented the resident had an unstageable (type of pressure ulcer where wound bed was obscured by non-viable tissue) pressure ulcer on their coccyx (tailbone) that was 6 centimeters x 3 centimeters x 1.5 centimeters with 0.3 centimeters of undermining (wound edges separate from surrounding healthy tissue creating a pocket). Slough (tan/grey non-viable tissue) was noted with moderate serosanguinous (combination of blood and serum, the clear part of blood) and odor (possible indication of infection). A wound care consult was ordered.</p> <p>The 6/16/2022 Nurse Practitioner #7 progress note documented nursing staff had concerns of a sacral wound which was not present during the last routine examination. The resident reported pain at the wound site requiring oral narcotics. The wound was assessed as a large unstageable sacral ulcer with odor and sloughing eschar (brown/black non-viable tissue). Wound care orders were in place and an immediate referral to outpatient wound care was recommended.</p> <p>The 6/23/2022 outside Wound Care Nurse Practitioner #9 progress note documented the resident had a Stage 4 pressure ulcer with moderate serosanguinous drainage measuring 8 centimeters x 8 centimeters x 1.8 centimeters with undermining between 8 to 10 o'clock that was 0.9 centimeters. The wound was mostly covered in eschar and slough which was debrided (removal of dead tissue using a scalpel).</p> <p>The 6/24/2022 at 11:23 AM Registered Dietitian #4 progress note documented they were made aware the resident had impaired skin and their intakes were fair at 25-75%. Promod (high protein supplement) was recommended twice daily to promote wound healing. There was no documented evidence the resident's protein and calorie needs were reassessed to accommodate increased needs for wound healing and to ensure the resident's provided food and fluids met their nutritional needs.</p> <p>The 7/1/2022 outside Wound Care Nurse Practitioner #9 progress note documented the resident's Stage 4 pressure ulcer was 8 centimeters x 7.8 centimeters x 1.8 centimeters and the wound continued to make minimal progress.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 7/6/2024 at 10:24 PM Registered Dietitian #4 progress note documented the Interdisciplinary Team met to discuss the resident. The resident received a regular consistency diet, consumed 50% of meals, and received a protein supplement. There was no documented evidence the resident's protein and calorie needs were reassessed to accommodate increased needs for wound healing.</p> <p>The 7/7/2022 at 5:26 PM Registered Nurse #10 note documented the resident was sent to the hospital from their wound care appointment.</p> <p>The 7/13/22 hospital discharge summary documented the resident was treated by an outside wound consultant and at their 7/7/2022 wound appointment, the resident's wound was noted with odor and drainage and sent to the hospital. At the hospital, the resident was found with a large infected sacral ulcer with foul odor, exposed bone and surrounding necrotic (dead) tissue. Debridement was done by surgery and a wound vacuum assisted closure device was applied.</p> <p>During an interview on 8/23/2024 at 10:22 AM and on 9/6/2024 at 10:09 AM, Registered Dietitian #4 stated they were notified of resident skin issues during morning report however, they could not recall if this was the process when Resident #1 was admitted . When a resident's wound healed, they were also notified in morning report. They stated they should assess nutritional needs within 5 days after a skin impairment was found. A resident's nutritional needs changed when they had a wound and protein needs needed to be increased because protein helped with wound healing. When the resident initially developed a skin impairment, their nutritional needs would have changed from their initial assessment on 4/26/2022. On 6/7/2022, they did not recall how they became aware the resident's wound had healed when they discontinued Ensure and was not aware the wound treatment continued. When the resident developed a Stage 4 pressure ulcer, their needs would have changed again, and they would have increased nutritional needs. The resident should have been reassessed when the wound worsened. The resident was consuming 25-100% of meal and that could be inadequate calories and protein to promote wound healing.</p> <p>During an interview on 9/4/2024 at 8:20 AM, the Director of Nursing stated pressure ulcers, skin with moisture issues, and skin tears were tracked weekly because they could see changes to skin from week to week and keep dietary and therapy involved with changes. The registered dietitian should be involved with wounds and either the Nurse Manager or Wound Nurse was responsible for notifying them. They expected the registered dietitian to be notified within 24 hours during the week. If the registered dietitian made a recommendation, the physician determined if it would be implemented, and it required an order. Once the order was obtained, it should be implemented as soon as nursing confirmed the order.</p> <p>During a telephone interview on 9/9/2024 at 8:28 AM, the facility's current Medical Director stated it was important for the registered dietitian to be involved with wounds and residents were typically put on some sort of liquid protein to assist with wound healing. They expected the registered dietitian to reassess resident nutritional needs when a wound was found or worsened. If a resident did not receive adequate nutritional intake, it could potentially contribute to wounds worsening.</p> <p>2) Resident #88 had diagnoses including Alzheimer's disease, depression, and age-related physical debility. The 7/24/2024 Minimum Data Set assessment (a health screen tool) documented the resident had severely impaired cognition, weighed 120 pound, had no significant weight changes, received a mechanically altered diet, and had 1 Stage 3 pressure ulcer (full thickness tissue loss) that was not present on admission.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE  282 Riverside Dr Johnson City, NY 13790	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Comprehensive Care Plan initiated 12/9/2022 documented the resident was at risk for skin injury related to advanced age, frail skin. The revised 5/10/2024 care plan documented a pressure ulcer on left plantar 9(bottom) foot. Interventions included administer treatments as ordered.</p> <p>The Comprehensive Care Plan initiated 12/9/2022 documented the resident was at risk for alteration in nutrition related to depression, hypertension, and difficulty swallowing. Interventions included set up for meals with intermittent verbal cues. On 4/17/2024 interventions were updated to include Ensure Plus (a nutritional supplement) at all meals and fortified pudding at dinner.</p> <p>The 7/22/24 Quarterly Nutrition Review completed by Registered Dietitian #3 documented the resident received a ground consistency house diet, received Ensure Plus three times daily, an extra sandwich at lunch, and fortified pudding once daily at dinner. The resident weighed 119.3 pounds (54 kilograms), their body mass index was 23.3 (healthy), and had not had significant weight changes in the past six months. The resident had a Stage 3 pressure ulcer on their left foot. Their estimated daily nutritional needs were 1200 calories (22 calories/ kilogram of body weight), 69 grams protein (1.3 grams of protein per kilogram of body weight), and 1330 milliliters (25 milliliters per kilogram of body weight).</p> <p>The 8/13/2024 Wound Care Nurse Practitioner #42 progress note documented the resident was seen for follow up for their Stage 3 left foot pressure ulcer. The resident had poor oral intakes. The wound was worsening, it measured 1 centimeter x 0.9 centimeters x 0.6 centimeters, had undermining (erosion under the wound edges) from 1 o'clock to 1 o'clock, and the wound had heavy amounts of serosanguineous (a mix of blood and serum) exudate (drainage). Recommendations included a nutritional consult for the presence of the wound, with moderate to high risk for complications and to re-evaluate current supplementations.</p> <p>There was no documented evidence a nutrition consult was completed for the resident.</p> <p>The 8/21/2024 physician order documented the resident was to receive 100 milligrams of Doxycycline (antibiotic) twice daily for day 10 days for a wound infection.</p> <p>The 8/27/2024 Registered Dietitian #3 progress note documented the resident continued with a Stage 3 pressure ulcer to their left foot. They had recently started on antibiotics and fluids were to be encouraged. The resident weighed 114 pounds, had no significant weight changes, and their oral intakes were variable. Their estimated fluids needs were 1785 milliliters of fluids (35 milliliters of fluid per kilogram). The resident continued to receive whole milk at all meals, an additional sandwich at lunch, fortified pudding, and Ensure Plus at all meals. A Magic Cup (nutrition supplement) would be added at lunch and fortified pudding would be provided at the dinner meal instead of the lunch meal.</p> <p>During an interview on 9/13/2024 at 8:17 AM, Wound Care Nurse Practitioner #42 stated wound rounds were done weekly with the Assistant Director of Nursing and the registered dietitian did not round with them. The facility let them know which residents needed to be seen. They communicated their recommendations to the Assistant Director of Nursing who passed the recommendations on to the Interdisciplinary Team. They stated nutrition played a role in wound healing. Resident #88 has a Stage 3 pressure ulcer on their left foot. They had recommended a nutritional consult as the resident's wound had worsened and they were at high risk. They expected the registered dietitian to make them aware of any nutritional recommendations to follow up on. They were unaware a nutrition consult was not done.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/2024 at 11:39 AM Registered Dietitian #3 stated they used to go on wound rounds but did not go anymore. The Assistant Director of Nursing sent out a weekly wound sheet that documented the residents who had wounds, the stage of the wounds, and any recommendations the wound care physician had. They had 2 weeks to follow up with recommendations. Nutrition played an important role in wound healing. Residents who had wounds had increased nutrient needs, which included calories and protein. They stated Resident #88 had a Stage 3 pressure ulcer on their left foot. They had last assessed the resident's nutritional needs on 7/22/2024 at the lower end of their needs for protein and calories. They were unsure if they were made aware of the recommendation for a nutrition consult on 8/13/2024. They reassessed the resident's fluid needs on 8/27/2024 and added a magic cup when they were receiving antibiotic for an infected wound. They stated they did not follow up timely.</p> <p>During an interview on 9/16/2024 at 12:17 PM, the Assistant Director of Nursing stated wound rounds were completed weekly at the facility. The Wound Care Nurse Practitioner and the Director of Therapy attended wound rounds and the registered dietitian sometimes did. They documented the wound care physician's recommendations and sent them out to the interdisciplinary team. The registered dietitian should be reviewing the wound notes and following up on recommendations as nutrition played a role in wound healing. They stated Resident #88 had a Stage 3 pressure ulcer on their left foot and received antibiotics due to the wound becoming infected. They were unsure what the nutrition protocols were for wound healing.</p> <p>3) Resident #2 had diagnoses including diabetes, Alzheimer's disease, and obesity. The 6/12/2024 Minimum Data Set assessment (health screening tool) documented the resident had severely impaired cognition, did not reject care, weighed 179 pounds, had no significant weight loss, and was at risk for pressure ulcers.</p> <p>The comprehensive care plan initiated 3/1/2022 and revised 3/22/2024 documented the resident was at risk for alteration in nutritional status related to diabetes and weight loss. Interventions included a sugar free diet, 4-ounce Health Shake (oral nutrition supplement) at all meals, and Magic Cup (nutrition supplement) at lunch and dinner.</p> <p>The 6/10/2024 Quarterly Nutrition Review by Registered Dietitian #4 documented the resident received a sugar restricted diet, 4-ounce Health Shake at all meals, weighed 179 pounds, had no known significant weight changes, and their skin was intact. Their estimated daily nutritional needs were based on 146 pounds (66 kilograms). Estimated calories were 1730 calories (26 calories per kilograms of body weight), 68 grams of protein (1 gram of protein per kilograms of body weight), and 1700 milliliters of fluids (25 milliliters per kilograms of body weight).</p> <p>A 7/30/2024 Licensed Practical Nurse #37 progress note documented a certified nurse aide made them aware the resident had an open area on their right buttocks. They notified the Wound Nurse, and the resident was seen by the Wound Care physician. New orders were obtained for treatment and the family was notified. New orders included to cleanse areas with wound wash, apply Medihoney (medicinal honey used for wound treatment) to wound base and cover with boarder dressing, change daily and as needed.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 7/30/2024 Wound Care Nurse Practitioner #42 progress note documented the resident was seen for a new skin and wound consult. The resident had a Stage 3 (full thickness tissue loss) wound measuring 1.2 centimeters x 1.5 centimeters x 0.2 centimeters. The treatment plan included cleanse area with wound cleanser, apply medical grade honey to the base of the wound, secure with border foam and change daily, and increase protein intake.</p> <p>There was no documented evidence the resident's protein needs were reassessed prior to the wound resolving on 8/13/2024.</p> <p>During an interview on 9/13/2024 at 8:17 AM Wound Care Nurse Practitioner #42 stated wound rounds were done weekly with the Assistant Director of Nursing and the registered dietitian did not round with them. The facility let them know which residents needed to be seen. They communicated their recommendations to the Assistant Director of Nursing who passed the recommendations on to the Interdisciplinary Team. They stated nutrition played a role in wound healing and they expected the registered dietitian to be made aware of any nutritional recommendations and to follow up.</p> <p>During an interview on 9/16/2024 at 11:39 AM Registered Dietitian #3 stated they used to go on wound rounds but did not go anymore. The Assistant Director of Nursing sent out a wound sheet weekly that documented the residents who had wounds, the stage of the wounds, and any recommendations the wound care physician had. They had 2 weeks to follow up with recommendations. Nutrition played an important role in wound healing. Residents who had wounds had increased nutrient needs, which included calories and protein. They stated Resident #2 had a Stage 3 pressure ulcer on their sacrum that was identified on 7/30/2024. They did not reassess the resident's needs when the wound was identified and did not follow up on the wound care physician's recommendations as it was an oversight. They did not see the resident again until 8/19/2024.</p> <p>During an interview on 9/16/2024 at 12:17 PM the Assistant Director of Nursing stated wound rounds were completed weekly at the facility. The Wound Care Nurse Practitioner and the Director of Therapy attended wound rounds and the registered dietitian sometimes did. They documented the Wound Care physician's recommendations and sent them out to the Interdisciplinary Team. The registered dietitian should review the wound notes and following up on recommendations as nutrition played a role in wound healing.</p> <p>10 NYCRR 415.12(c)(2)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49448</p> <p>Based on observation, record review, and interview during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and include the expiration date when applicable for 3 of 3 medication carts (Second floor short hall, Second floor long hall, and Third floor long hall) reviewed. Specifically,</p> <ul style="list-style-type: none"> <li>- the Second floor short hall medication cart contained 49 loose, unidentified pills; eye drops for Resident #446 without an opened or expired/discard date; inhalers for Residents #127, #118 and #47 without an opened or expired/discard date; and an inhaler without any resident identifiers.</li> <li>- the third-floor long hall medication cart had one loose pill; 2 opened medicated pain patches and a vial of nitroglycerin (treats chest pain) tablets without resident identifiers; an insulin (treats blood sugar) pen for Resident #14, eye drops for Resident #33, and inhalers for Residents #63, #18, and #16 that did not have opened or expired/discard dates.</li> </ul> <p>Findings include:</p> <p>The facility policy, Vials, effective 10/2004 documented multi-dose vials were dated and initialed when they were opened. The vials were discarded when they were empty or when the manufacturer's expiration date was reached, but not to exceed 28 days. All drugs were checked prior to use and ensured outdated drugs were not used. Multi-dose vials that were not dated when opened were disposed of 28 days after the date dispensed by the pharmacy. This was a quality control fail safe.</p> <p>The facility policy, Inhalers, revised 3/2011 documented inhalers were stored (labeled) in the medication cart and discarded when empty or expired. The expiration date was checked prior to administration.</p> <p>The facility policy, Medication/ Treatment Labeling and Storage, revised 7/2013 documented the facility maintained proper labels for medications and proper storing instructions. Medications without labels were returned to the pharmacy for destruction, all medications were stored in their original containers. Medication carts were kept clean, organized, restocked, and fully equipped.</p> <p>SECOND FLOOR SHORT HALL MEDICATION CART:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of the Second floor short hall medication cart with Registered Nurse #36 on 9/10/2024 at 3:14 PM there were Lumigan (treats eye pressure) 0.01% eye drops without an opened or expiration/ discard date for Resident #446; a Budesonide-Formoterol 80-4.5 microgram/ actuation inhaler, an albuterol sulfate (treats difficulty breathing) 90 microgram/ actuation inhaler with a pharmacy dispensed date of 7/22/2024 without an opened or expired/ discard dates for Resident #127; an albuterol sulfate 90 microgram/ actuation inhaler with a pharmacy dispensed date of 7/29/2024 without an opened or expired/ discard dates for Resident #118; and an albuterol sulfate 90 microgram/ actuation inhaler with a pharmacy dispensed date of 7/22/2024 without an opened or expired/discard dates for Resident #47. There were 49 loose, unidentified pills scattered in the medication drawer, and a Dulera (treats asthma) inhaler that did not have a resident identifier. Registered Nurse #36 stated any multi-dose medication should be dated as opened. If there was a medication that was not dated it should be discarded because it may not be good. It was important to know if medications were expired. Expired medications may not be as effective or overly effective. If Resident #446 was receiving expired eye drops their glaucoma (eye disease causing eye pressure and blindness) could progress. They were not sure of the policy on dating inhalers as opened but thought inhalers should be labeled as opened for the same reasons as the eye drops.</p> <p>During an interview on 9/10/2024 at 4:14 PM Licensed Practical Nurse #37 stated if a medication was not dated, they would not use it. An opened date on medications was important to know if the medication was expired. There could be a reaction if expired medications were given.</p> <p>THIRD FLOOR LONG HALL MEDICATION CART:</p> <p>During an observation of the Third floor long hall medication cart on 9/10/2024 at 4:00 PM with Licensed Practical Nurse #31, there was an opened vial of nitroglycerin tablets, an opened box 1% lidocaine (treats pain) patches, an opened box of 5% menthol patches (treats pain) with no resident identifiers; an opened multi-dose Lantus (long-acting) insulin pen for Resident #14 with a pharmacy dispensed date of 7/4/2024 without an opened or expired/ discard date; refresh liquid eye gel and eye drops for Resident #33 without an opened or expired/discard date; one loose round white pill labeled with AZ 011 in the third drawer of the medication cart; an opened fluticasone-vilanterol (treats breathing problems) 100-25 microgram/ actuation inhaler dispensed from the hospital with a due date of 4/1/2024 for Resident #63; a budesonide-formoterol (treats breathing problems) 160-4.5 microgram/ actuation inhaler with no opened or expired/ discard date for Resident #18; and an opened Combivent (treats breathing problems) 20-100 microgram/ actuation inhaler with no opened or expired/ discard date for Resident #16. Licensed Practical Nurse #31 stated without an opened date they would not know if the medication was expired, and all medications should have resident identifiers to ensure they were administered to the correct resident. If the resident's received expired medications, they may not be as effective or there could be negative effects. The opened/ expired date should be checked on all medications prior to administration. If they had medications that were not dated as opened, they should discard them, and a replacement would be ordered. Insulin was good for 30 days and they were not sure about eye drops or inhalers but went by the 30-day rule for expiration of medications.</p> <p>During an interview on 9/11/2024 at 1:28 PM Licensed Practical Nurse #24 stated expired medications might not be as effective or work as intended. They had administered the medications yesterday without opened or expired/ discard dates. They should have looked for the expiration dates and should have thrown away the undated medications and ordered new ones.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/16/2024 at 1:37 PM, the Assistant Director of Nursing stated medications should be dated when opened. The opened date was used to determine the expiration date. Without an opened date, it would not be known if the medication was still good. Residents should not receive expired medications. Staff should check the opened and/or expired date prior to administering a medication. If a medication was expired, it should be thrown away and the pharmacy should be called for a replacement. The pharmacy delivered twice daily during the week and once daily on the weekends.</p> <p>10NYCRR 415.18(d)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>43754</p> <p>48675</p> <p>Based on observation and interview during the recertification and abbreviated (NY00336546) surveys conducted 9/9/2024-9/16/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 1 of 2 meals (the 9/10/2024 dinner meal) reviewed and for 4 of 4 residents (Residents #15, #93, and #112). Specifically, food was not served at palatable and appetizing temperatures during the dinner meal on 9/10/2024. Additionally, Residents #15, #93, and #112 stated the food was served cold, and Resident #36 stated the food was not palatable and was served cold.</p> <p>Findings include:</p> <p>The facility policy, Food Preparation, Service and Distribution, revised 10/2022, documented:</p> <ul style="list-style-type: none"> <li>- Holding foods in the tray line or alternate meal preparation and service areas may include steam tables, where hot foods were held and served, and chilled areas where cold foods were held and served, would not hold foods in the danger zone (temperatures above 41 degrees Fahrenheit and less than 135 degrees Fahrenheit).</li> <li>- Dining locations included any area where one or more residents ate their meals. These included dining rooms or mobile food carts that maintained food in proper temperature and out of the danger zone.</li> <li>- Hot foods should be served hot and cold foods should be cold in accordance with resident preference.</li> </ul> <p>During an interview on 9/9/2024 at 11:27 AM, Resident #93 stated they usually ate their meals in their room and by the time it was served, the food was usually cold.</p> <p>During an interview on 9/9/2024 at 1:58 PM, Resident #15 stated meals were served cold and there was no microwave to reheat the food on the unit.</p> <p>During an interview on 9/9/2024 at 2:14 PM, Resident #36 stated the food did not taste good, did not look appealing, and was served cold.</p> <p>During an interview on 9/10/2024 at 9:19 AM, Resident #112 stated meals were often late and served cold.</p> <p>During a dinner meal observation on 9/10/2024 at 6:17 PM, Resident #71 was served their dinner meal tray. A replacement tray was ordered, and Resident #71's original tray was tested. The hamburger was measured at 118.4 degrees Fahrenheit, the noodles were 116.8 degrees Fahrenheit, the peanut butter and jelly sandwich was 46.2 degrees Fahrenheit, the applesauce was 67.5 degrees Fahrenheit, the coffee was 133.9 degrees Fahrenheit, and the water was 52.2 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/10/2024 at 6:19 PM, Certified Nurse Aide #30 stated if meals were not served at appropriate temperatures the food could grow bacteria and if ingested by the residents, they could get sick. They took a food safety course, and the hot food was supposed to be over 140 degrees Fahrenheit, and the cold food was supposed to be under 45 degrees Fahrenheit. They stated all the food/drink items on Resident #71's meal tray were not at appropriate temperatures.</p> <p>During an interview on 9/11/2024 at 1:05 PM, Food Service Director #40 stated they completed test trays two or three times a week along with the registered dietitian. They would send an extra tray to the unit, take the food temperatures, and taste the food to ensure quality. They stated they wanted hot food items over 135 degrees Fahrenheit, cold food items less than 55 degrees Fahrenheit, and milk less than 45 degrees Fahrenheit. Hot food items that measured between 116 degrees Fahrenheit and 118 degrees Fahrenheit was not appropriate, and applesauce should have been served cold and measured less than 67 degrees Fahrenheit.</p> <p>During an interview on 9/16/2024 at 11:16 AM, Registered Dietitian #4 stated they completed test trays once or twice a week throughout the facility. They tested the food temperature after it was cooked and would test it again when it was on the unit. They stated breakfast was hard because of the scrambled eggs and most of the residents' complaints were that breakfast was served cold. They would offer alternates if they received complaints. They stated it was important for food to be palatable and served at appropriate temperatures or the residents might not eat as much. They stated there was danger for food borne illness if temperatures were not in range, but they were unsure of specific temperatures. Their expectation was for all residents to have palatable foods.</p> <p>10NYCRR 415.14(d)(1)(2)</p> <p>49448</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>43754</p> <p>Based on observation, record review, and interviews during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure food was prepared, distributed, and served in accordance with professional standards for food service in the facility's main kitchen and Third floor kitchenette. Specifically, in the main kitchen, there was debris on the floors and counters, unclean areas, a drain back up, gloves were not used properly, and food was not cooled properly. The Third floor kitchenette was unclean.</p> <p>Findings included:</p> <p>The facility policy, Grease Traps, revised 12/2006, documented the facilities safety elements of the environment were maintained, tested , inspected, and included checking the grease traps monthly. Staff should maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.</p> <p>The facility policy, General Kitchen Cleaning, revised 6/1/2023, documented staff shall maintain sanitation of the kitchen through compliance with a written comprehensive cleaning schedule.</p> <p>The facility policy, Food Cooling Temperature Log, effective 7/2008, documented staff would ensure the proper temperatures for chilling of foods to eliminate food borne illness. All potentially hazardous foods were cooled from 135 degrees Fahrenheit to 41 degrees Fahrenheit within six hours or less.</p> <p>The following observations were made in the main kitchen on 9/9/2024:</p> <ul style="list-style-type: none"> <li>- at 9:42 AM, the dry storage area had debris on the floor and under the shelving.</li> <li>- at 9:46 AM, there was food debris under and around the cookline equipment.</li> <li>- at 9:48 AM, the 2 bay sink at the end of the cookline was leaking from the right-side faucet, there was grime build up on the plumbing, and a bus pan was full of moldy stagnant liquid beneath the sink plumbing. There were numerous ant bait stations, glue traps, and steel box traps for pests throughout the kitchen.</li> <li>- at 9:57 AM, the cooler was labeled out of order and handwritten next to the out of order sign was for two years and counting. The cooler had food spills and debris inside.</li> <li>- at 10:00 AM, the walk-in freezer had food debris on the floors and under the shelving, there was ice piling up beside the door.</li> <li>- at 10:01 AM, there was a yellow dried puddle under shelving of the walk-in cooler.</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Riverside Dr Johnson City, NY 13790	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- at 10:07 AM, there was a significant amount of food debris on the floor under the ice machine and around the floor drain. There was debris where water had backed up from the floor drain by the back door.</p> <p>The following observations were made in Third floor kitchenette on 9/9/24:</p> <p>- at 9:37 AM, there were sugar packets scattered on the floor.</p> <p>- at 9:39 AM, the right side of the warmer was not clean.</p> <p>- at 9:41 AM, a dirty black plastic bin under the sink was full of water with a white/grey film on the surface of the water.</p> <p>- at 9:45 AM, the faucet of the large sink basin was leaking behind the cold water handle.</p> <p>- at 9:49 AM, the stainless-steel shelving in the middle island had dried food debris on the bottom shelf.</p> <p>- at 9:56 AM, the walk-in freezer had food debris on the floor and ice buildup on the door.</p> <p>- at 10:00 AM, there was food debris behind the ice machine</p> <p>- at 10:02 AM, the eye wash station was unclean with food debris.</p> <p>- at 10:04 AM, the paper towel dispenser had a dried white/gray substance covering it.</p> <p>The following observations were made in the main kitchen on 9/10/24:</p> <p>- at 10:10 AM, there was debris and grease staining under and around the cook line equipment and tables.</p> <p>- at 10:10 AM, there was a dirty bus pan.</p> <p>- at 10:11 AM, there was debris and drain back up by the back door, ice machine, and around the mop sink area. Dish racks were stacked and stored on the floor by the ice machine.</p> <p>- at 10:27 AM, the out of order cooler had debris and food spills.</p> <p>- at 10:28 AM, the kitchen floors were unclean and had a tacky/sticky built up layer of grease and grime.</p> <p>- at 10:39 AM, the walk-in freezer had several cases of food stored directly on the floor. There was food debris and excessive icing on the floor.</p> <p>During an observation on 9/10/2024 at 10:09 AM and 10:19 AM, the third-floor kitchenette area ice machine was dirty, and the floors were sticky.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation in the main kitchen on 9/11/2024 at 12:11 PM, there was food debris under the refrigerator at the end of the cook line, and at 12:12 PM the floor around the ice machine and back door had a significant amount of food debris and drain backup strewn around the ice machine and leading to the back door.</p> <p>During an observation in the main kitchen on 9/11/24 at 1:18 PM, there was a six-inch square pan wrapped in plastic wrap labeled grilled cheese PR (pureed) 9/11 just inside the walk-in cooler door on a middle shelf. The pureed grilled cheese temperature was measured at 104 degrees Fahrenheit. At 1:43 PM, the pan and contents measured at 98 degrees Fahrenheit. At 1:47 PM, Food Service Director #40 placed the pureed grilled cheese in the walk-in freezer and uncovered the product.</p> <p>During an interview on 9/11/24 at 1:51 PM, [NAME] #55 stated when they made food items like pureed grilled cheese, they put it in the freezer. They had also made a cold three bean salad and put that in the walk-in cooler by accident. They stated the pureed grilled cheese was made about an hour or two prior to the observation. They normally documented only when they checked the temperatures for food items like turkey. They stated the cooling requirement when meat was put in the oven to be used the next day, it must be cooled down within 2 hours, or 4 hours after that. [NAME] #55 referred to the cooling log sheet for guidance and stated the temperature was required to be around 70 (degrees Fahrenheit) and below after two hours, and 40 (degrees Fahrenheit) and below after another 4 hours. The grilled cheese would not meet the cooling requirement if it was left in the walk-in cooler. They would have to discard the food and start over because it would not meet the cooling requirements.</p> <p>During an interview on 9/12/2024 at 11:42 AM, Housekeeping Aide #39 stated they took out the trash in the Third floor kitchenette, wiped down the tables, and mopped after lunch. They stated they were not trained to wipe down the refrigerator.</p> <p>During an interview on 9/13/2024 at 1:34 PM, the Food Service Director stated they were not sure who cleaned the kitchenettes. They stated the shelf was stained from spilled cranberry juice. The faucet in the main kitchen was leaking for one month. They stated over the weekend they noticed the grease in the bus pan, and they discarded it. The floors in the kitchen were cleaned daily and the floors in the walk-in coolers were cleaned weekly. There was a problem with the floor drain earlier in the week when it got clogged. They were not sure when the water backed up by the ice machine. Food and debris should not be on the floors, under equipment, or in the coolers. It was important to keep the kitchen and kitchenette clean and to cool foods properly for the safety of the residents.</p> <p>10NYCRR 415.14(h)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50561</p> <p>Based on observation, record review, and interviews during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 2 residents (Resident #137) reviewed. Specifically, appropriate hand hygiene was not performed by Licensed Practical Nurse #31 during a wound care treatment for Resident #137.</p> <p>Findings include:</p> <p>The facility policy, Dressing-Clean Technique, revised 12/2007, documented a clean dressing technique was used to provide an appropriate and safe environment conducive to wound healing and should be used during all dressing changes unless otherwise specified by the physician, and gloves should be changed, and hands washed after the removal of a soiled dressing.</p> <p>Resident #137 had diagnoses including Parkinson's disease (a progressive neurological disorder) and a local infection of the skin and subcutaneous tissue. The 7/29/2024 Minimum Data Set documented the resident had intact cognition, an unstageable pressure injury, and was taking an antibiotic daily.</p> <p>The Comprehensive Care Pan last reviewed 8/9/2024, documented the resident had a skin integrity problem related to a sacral ulcer wound, left heel and right heel deep tissue injury (a maroon/purple area of intact skin due to underlying damage). Interventions included administer treatment as ordered. The resident was at risk for infection related to a wound infection on 7/31/2024. Interventions included treatment per physician order and observe for signs and symptoms of infection.</p> <p>The 7/30/2024 physician order documented sacral wound to be cleansed with half strength Dakin's solution (use to prevent and treat skin and tissue infections), apply skin prep (a skin protectant) around perimeter of wound, apply fluffed Dakin's (antiseptic) soaked gauze to wound base, do not pack, cover with foam 6 x 6 dressing daily and as needed if soiled or dislodged.</p> <p>The 9/2/2024 physician order documented Tetracycline HCl Oral Capsule (an antibiotic) four times a day for 10 Days for wound infection.</p> <p>During a wound care observation on 9/12/2024 at 2:24 PM, Licensed Practical Nurse #31 removed a soiled dressing from the resident's sacral wound, moistened clean gauze with Dakin's solution, cleansed the wound, moistened more gauze with Dakin's, and applied gauze to the wound bed. Licensed Practical Nurse #31 did not change gloves or perform hand hygiene after removing the soiled dressing and before applying a clean dressing.</p> <p>Licensed Practical Nurse #31's personnel file documented they completed Hand Hygiene Competency Test on 8/18/2023 and on 8/31/2024 participated in the Infection Control Clinic.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24 at 2:46 PM, Licensed Practical Nurse #31 stated hand hygiene should be done before and after entering a room and in between glove changes. During a dressing change, gloves should be changed after removing the old dressing and after cleansing the wound. Their gloves were potentially soiled if they touched a dirty dressing and if they touched clean dressing supplies with those same gloves. The dirty gloves could contaminate the clean dressing supplies. If the clean supplies touched the wound, it could contaminate the wound and cause an infection which could cause the wound to get worse. The resident had a history of wound infection and was currently being treated for an infection.</p> <p>During an interview on 9/16/2024 at 1:24 PM, Licensed Practical Nurse Unit Manager #1 stated hands should be washed and clean gloves applied before and after removing an old dressing, after cleansing the wound, and after applying a new dressing. If clean gloves touched something dirty, they should discard those gloves, wash their hands, and apply new gloves. If gloves were dirty and the nurse touched clean supplies those supplies would be contaminated and they would have to start the wound care all over again. This caused a risk for infection. Resident #137 currently had an infection to the sacral wound and had a history of wound infections.</p> <p>During an interview on 9/16/2024 at 5:03 PM, the Director of Nursing stated during wound care hand hygiene should be performed and clean gloves applied before starting wound care. After removal of soiled dressing gloves should be removed, hand hygiene performed, and new gloves applied before cleansing the wound and applying a new dressing. At completion of wound care, hand hygiene should be performed after removing gloves. Resident #137 currently had a Stage 4 (full thickness tissue loss with exposed muscle, tendon, or bone) pressure ulcer on their sacrum and was currently on Tetracycline (antibiotic) for infection of that pressure ulcer.</p> <p>10NYCRR 415.19(b)(1)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675</b></p> <p>Based on observation, record review, and interview during the recertification survey conducted 9/9/2024-9/16/2024, the facility did not ensure they were adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized work area for 1 of 1 resident (Resident #90) reviewed. Specifically, Resident #90's call bell did not function as designed and they did not have the means of directly contacting caregivers. Findings include:</p> <p>The facility policy Call Lights, revised 10/24/2022, documented all residents would be provided with a method to communicate requests and needs, directly to staff or a centralized work area from the bedside, bathing, and bathroom areas through audible signals, visible signals, or electric/wireless systems. The facility would have a process to routinely ensure the call system for residents was operational. If a call light was defective, staff would report immediately to maintenance and the charge nurse. Staff would provide the resident with an alternate means of calling for assistance.</p> <p>Resident #90 had diagnoses including dementia and cerebral infarction (stroke). The 7/12/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent with bed mobility and transfers, required partial/moderate assistance with personal hygiene, and had no functional limitation in their range of motion in their upper or lower body.</p> <p>The Comprehensive Care Plan revised 5/3/2024 documented the resident was at risk for falls related to cognition, elimination, and mobility. Interventions included keeping items on the nightstand or within reach. There was no documentation to keep the call bell within reach.</p> <p>During an observation and interview on 9/9/2024 at 12:05 PM, Resident #90 was lying in bed with their call bell draped over their lap. The resident attempted to use their call bell and stated they wanted their legs moved but their call bell did not work. The call bell did not activate when pushed. The resident stated they would just yell out until staff heard them when they needed something.</p> <p>During an observation on 9/9/2024 at 12:28 PM, Resident #90 was calling out for a nurse. Certified Nurse Aide #25 entered the resident's room. At 12:30 PM Certified Nurse Aide #25 exited Resident #90's room and told Licensed Practical Nurse #26 the resident's call bell was not working and Licensed Practical Nurse #26 stated they would contact maintenance.</p> <p>During an observation and interview on 9/10/2024 at 9:25 AM, Resident #90 was lying in bed with their call bell clipped to the right side of the bed. They stated their call bell was still broken and staff was too busy to fix it. The call bell did not activate the alarm or light when pushed.</p> <p>During an interview on 9/13/2024 at 9:26 AM, Certified Nurse Aide #25 stated they cared for Resident #90 on 9/10/2024 during the day shift and they were not aware their call bell was not working. They stated they would have notified the nurse and the maintenance department. They were not familiar with work orders, and they did not know how to complete them. They stated it was important for the resident to have a working call bell for safety reasons.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/13/2024 at 9:45 AM, Licensed Practical Nurse #26 stated Resident #90 was on their assignment on 9/9/2024 and 9/10/2024. They could not recall if they were made aware Resident #90's call bell was not working. If they were made aware, they would have contacted maintenance. They did not know how to use the work order system so they would call maintenance when they needed them. They stated it was important for the resident to have a working call bell so they could notify staff when they needed assistance.</p> <p>During an interview on 9/13/2024 at 10:35 AM, Registered Nurse Supervisor #27 stated they were covering unit 3 all week and they were not aware Resident #90's call bell was not working. They stated they should have been made aware because they had extra call bells they could have tried, or they would have provided the resident with a tap bell until it was fixed. They stated it was important for the resident to always have a working call bell so they could communicate with staff and for their safety.</p> <p>During an interview on 9/13/2024 at 1:02 PM, Certified Nurse Aide #28 stated they were aware Resident #90's call bell was not working on the morning of 9/9/2024. They notified Licensed Practical Nurse #26 and they attempted to call maintenance multiple times, but they could not get in contact with maintenance. They stated they notified the Director of Nursing the call bell was not working at the end of their day shift. They had never completed a work order were unsure how to do it. They stated it was important for the resident and all residents to have a working call bell for their safety.</p> <p>During an interview on 9/13/2024 at 1:20 PM, Plant Operation Director #29 stated they were notified of a broken call bell in room [ROOM NUMBER] earlier that week. They received a work order on 9/9/2024 at 2:00 PM but they were not able to get to it until the morning of 9/10/2024. They stated they preferred work orders instead of staff members calling them so they could keep track of the issues and when they were addressed.</p> <p>10 NYCRR 415.29</p>		