STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335394	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wesley Health Care Center Inc	131 Lawrence Street Saratoga Springs, NY 12866

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742 Based on observation, record review, and interviews during the recertification survey and abbreviated survey (NY00356338), the facility did not ensure each resident was treated with respect and dignity and cared for in a manner and in an environment that promoted maintenance or enhancement of their quality of life, recognizing each resident's individuality for 2 (Resident #s 6 and 33) of 7 residents reviewed for dignity. Specifically, for (a.) Resident #6 was left to soil themselves because staff did not attend to the resident in a timely fashion, leaving the resident feeling humiliated on more than one occasion. Resident #33 was not assisted with the consumption of their observed meal in a dignified manner. This is evidenced by: A facility policy titled Promoting Dignity and a Safe Environment Guidelines, dated 03/12/2024 documented it was designed to provide a safe, respectful, and dignified environment for all residents. A facility policy titled Feeding a Resident, dated 11/12/2024 documented under section 2. Feeding a resident: c. staff should sit not standing over residents. Resident conversation should be engaging and resident-appropriate, keep private staff conversations for break time. A facility policy titled Resident Rights, dated 03/2024, documented that the facility would ensure residents had the right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration and privacy in treatment and care for personal needs, and communication with and access to persons and services inside and outside the facility. Resident #6 Resident #6 was admitted to the facility with diagnoses of chronic kidney disease, dependence on renal dialysis (a treatment that removes waste and excess fluid from the blood when the kidneys are no longer functioning properly), and difficulty walking. The Minimum Data Set (an assessment tool) dated 10/16/2024 documented the resident was able to be understood, understand others, was cognitively intact and required significant assistance with activities of daily living. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's Comprehensive Care Plan for incontinence, undated, documented the resident's goals included remain free of odor and moisture associated skin damage. Interventions were check for incontinence; clean and dry skin if wet or soiled and dress in clothing that is easily removed for toileting. During an interview on 11/18/2024 at 2:29 PM, Resident #6 stated that the facility was short on staff. They stated few days ago they called for medications and for the restroom around 7:00 PM, staff did not come until 10:00 PM. This happened at least one time per week but usually several times per week. On a good day they answer the call light in 3 hours and on a bad day no one comes after turning their light off. Resident #6 stated several times they were left to the point that they soiled themselves and were embarrassed by this. They stated they were left soiled until the urine was up to the resident's belly area without assistance. During an observation on 11/19/2024 at 9:48 AM, the call light was engaged for room [ROOM NUMBER]; the call light was answered 27 minutes later at 10:15 AM. During an interview on 11/19/2024 at 12:28 PM, Registered Nurse #4 stated they were alone on the unit without other nurses and could not interview at that time. Resident #33 Resident #33 was admitted to the facility with diagnoses of dysphagia (difficulty swallowing), hemiplegia, and hemiparesis (muscle weakness or partial paralysis on one side). The Minimum Data Set, dated dated dated [DATE], documented the resident was usually able to make themselves understood, usually able to be understood by others, and severely cognitively impaired. During an observation 11/12/2024 at 12:29 PM, Resident #33 sat in the wheelchair at the dining room table on the third floor of Springs tower. Staff asked and placed a clothing protector. Licensed Practical Nurse #1 assisted Resident #33 with the noon meal, they turned to converse with other staff at the table of six residents with six staff assisting and four staff were engaged in the conversation, not paying attention to the residents they were assisting. Resident #33 was seen during this time chewing/sucking on her clothing protector. One resident was leaning towards the fork the staff was holding out of reach while their head was turned away from the resident. One resident was reaching for the food on the plate while the staff was paying attention to the conversation of other staff. During an observation and interview on 11/12/2024 at 12:29 PM, Certified Nurse Aide #1 stated residents should be assisted at meals when needed and the staff should pay attention and keep their concentration on the resident, they were assisting. This was a dignity issue for the resident. During an interview on 11/12/2024 at 12:29 PM, Licensed Practical Nurse #1 stated they should keep their attention on the resident they were assisting with meals through the entire meal. They apologized for their behavior during the meal. They confirmed it was a dignity issue. During an interview on 11/12/2024 at 12:43 PM, Director of Nursing #1 and Assistant Director of Nursing #1 stated all residents that required assistance with eating should receive it with dignity. This would be the staff assisting them would pay attention to them and not to participate in outside conversations with other staff, in doing this was a resident dignity issue. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Code Rules and Regulations 415.5(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 48744 Based on record review and interviews during the recertification survey, the facility did not ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for 1 (Resident #243) of 35 residents reviewed. Specifically, there was no documentation that a Preadmission Screening and Resident Review (PASARR, New York State Department of Health form 695) was completed for Resident #243 by a qualified screener prior to admission to the facility. This is evidenced by: Resident #243 was admitted to the facility with diagnoses of malignant neoplasm of prostate (prostate cancer that spread to other parts of the body), secondary malignant neoplasm of bone (cancer that spread to the bone from the prostate), and difficulty walking. The Minimum Data Set (an assessment tool) dated 8/29/2024 documented that the resident was able to be understood, understand others, and was somewhat cognitively impaired. There was no documented evidence that Residents #243 had a Preadmission Screening and Resident Review completed prior to admission to the facility as required. During an interview on 11/19/2024 at 8:54 AM, Admissions Coordinator #1 stated that there was no Preadmission Screening and Resident Review for Resident #243 and that they were not aware there was not one done until the survey team asked for it. Resident #243 was admitted through hospice from home. The Hospice admission person was supposed to send the screen and never did. Admissions Coordinator #1 stated they reached out to the Hospice team to have it sent over upon discovery that it had not been. Hospice was unable to find the Preadmission Screening and Resident Review in question. Admission Coordinator #1 stated they would complete the screen as soon as possible. During an interview on 11/19/2024 at 12:54 PM, Administrator #1 stated there would be a Performance Improvement Plan for addressing Resident #243's missing Preadmission Screening and Resident Review. Administrator #1 stated the facility usually did not have an issue with having completed Preadmission Screening and Resident Reviews or making sure they were completed before residents were admitted . Administrator #1 stated that Admissions Coordinator #1 was very stressed at the time Resident #243 was admitted and Resident #243's missing Preadmission Screening and Resident Review was a one-off situation. 10 New York Code of Rules and Regulations 415.11(3)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48413 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions for 1 (Resident #68) of 39 residents reviewed. Specifically, for Resident #68, the Comprehensive Care Plan for Respiratory Therapy was not reviewed and revised to include changes in the resident's respiratory status when resident was not using oxygen. This is evidenced by: A review of the facility policy titled Respiratory Therapy Program dated 4/18/2023 documented the facility was to provide respiratory therapy assessment and treatment to those residents with deficiencies or abnormalities of pulmonary function, for whom a provider's order has been written. Resident #68 was admitted to the facility with diagnoses of sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection that may lead to organ failure or death), rhabdomyolysis (a serious condition when muscle fibers die and release their contents into your bloodstream), and paroxysmal atrial fibrillation (a condition of having an irregular heartbeat). The Minimum Data Set (an assessment tool) dated 10/23/2024 documented that the resident could be understood, and usually understand others, and had intact cognition for daily living decisions. During an observation on 11/12/2024 at 12:49 PM, Resident #68 was not receiving oxygen, and a nasal cannula was connected to an oxygen concentrator as well as one attached to the portable oxygen tank in their wheelchair. During an observation on 11/15/2024 at 10:27 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There was no oxygen tubing on the resident concentrator, and it was unplugged. During an observation on 11/18/2024 at 10:12 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There was no oxygen tubing on the resident concentrator, and it was unplugged. A review of the Treatment Administration Record on 11/15/2024 for November 2024, documented that Resident #68 was to be on continuous oxygen therapy at 2 liters per minute via a nasal cannula and was to be changed once weekly. The nasal cannula tubing was documented as last being changed on 11/10/2024. The record further documented that staff ensured residents' oxygen was in place and functioning every four hours. The Treatment Administration Record documented that staff was signing off that the resident's oxygen was in place consistently for November 2024 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #68 Care Plans dated 10/17/2024 documented resident had the potential for respiratory complications due to prolonged hospitalization , pain, and a new need for oxygen. The care plan further documented the resident was to have oxygen administered per the Medical Director's order. A review of the physician order sheet documented Resident #68 was to be on continuous oxygen at 2 liters per minute via nasal cannula. During an interview on 11/12/2024 at 12:49 AM, Resident 68 stated that they only wore the oxygen at night. They mentioned that they came to the facility with oxygen on and the facility had placed it on them but believed they did not require it as they did not wear it at home and had no issues with breathing. During a follow-up interview on 11/18/2024 at 10:12 AM, Resident #68 stated that they were not on oxygen over the weekend. They stated that they had not been on oxygen in quite some time. They stated they were not sure why there was oxygen as they feel they do not require it. Resident #68 stated that they had never used the portable oxygen tank that was located in their wheelchair. During a subsequent interview on 11/19/2024 at 9:40 AM, Resident #68 stated that they had not been on oxygen much since they had been at the facility. The resident was not on oxygen during their morning physical therapy session. During an interview on 11/19/2024 at 9:50 AM, Registered Nurse #2 stated that Resident #68 had an order for oxygen but stated they hardly wore it. They stated that they have had conversations with the team about discontinuing the oxygen for the resident but had not heard from the physician at all. They stated that the resident had not been on oxygen for approximately 5-6 days and their oxygen saturation was above 95%. Mentioned findings to Registered Nurse #2 and they verified that the staff have been verifying resident was wearing their oxygen and documenting it in the Treatment Administration Record. They stated that staff should be documenting that the resident was not on oxygen. 10 New York Code of Rules and Regulations 483.21 (b)(2)(iii)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 51742 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that it provided an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 (Resident # 80) of 2 residents reviewed for activities. Specifically, Resident #80 was not provided with activities that met the residents' preferences and cognitive abilities. This is evidenced by: The Policy titled General Activity/Life Enrichment Program Guidelines dated 03/01/2024 document the facility would provide activities, social events, and schedules that were compatible with the resident's interests, physical and mental assessment, and overall plan of care. The Policy documented activities were offered 7 days a week and should provide ongoing supportive program of the resident's psychosocial needs. Resident #80 was admitted to the facility with diagnoses of dementia, anxiety, and major depressive disorder. The Minimum Data Set (an assessment tool) dated 10/16/2024 documented the resident was severely cognitively impaired, could be sometimes understood, and sometimes understand others. The Comprehensive Care Plan documented that staff were to help Resident #80 with all activities of daily living. Care Plan lacked documentation of any activity preferences for Resident #80. During an observation on 11/15/2024 at 09:14 AM, Resident #80 was tucked under the dining room table, had breakfast in front of them. Received no assistance and had spilled eggs on her lap, bacon directly on the table, and no staff around for assistance. During an observation on 11/18/2024 at 7:54 AM, Resident was tucked under the dining room table facing the corner of the dining room and calling out help me. No staff noted nearby. During an observation on 11/18/2024 at 10:54 AM, Resident #80 was at the dining room table, tucked under the table, was resting with eyes closed. Resident had nothing in front of them. During an observation on 11/19/2024 at 9:46 AM, Resident #80 was sitting in their wheelchair in the hallway. No activity/interaction, tearful, calling out again help me. During an observation on 11/19/2024 at 12:08 PM, Resident #80 was sitting at the dining room table tucked in and calling I want to go home, help me, mother please help. During an interview 11/19/2024 at 12:28 PM, Registered Nurse #4 stated they were alone on the floor so did not have time interview. During an interview 11/19/2024 at 12:29 PM, the Director of Nurses #1 stated that life enrichment should provide activities for all residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2024 at 3:20 PM, Life Enrichment director #1 stated the life enrichment staff assigned to Spring tower floor 2, was out sick on this date. The interdisciplinary team meets regularly and discuss each resident. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that were following professional standards of practice, for 3 (Residents #'s 49, 53, and 68) of 6 residents reviewed for oxygen administration. Specifically, (a) for Residents #49, 53, and 68, their supplemental oxygen tubing was not dated and labeled to reflect when the tubing was changed; and (b) supplemental oxygen was not provided as ordered by the physician for Resident #68. This is evidenced by: A review of the facility policy titled Respiratory Therapy Program dated 4/18/2023 documented the facility was to provide respiratory therapy assessment and treatment to those residents with deficiencies or abnormalities of pulmonary function, for whom a provider's order had been written. Resident #49 was admitted to the facility with diagnoses of chronic respiratory failure (a condition where you do not have enough in the tissues), dependence on supplemental oxygen, and chronic systolic (congestive) heart failure (a chronic condition in which the heart does not pump blood as well as it should). The Minimum Data Set (an assessment tool) dated 9/06/2024, documented the resident had severe cognitive impairment, could be understood, and understand others. It documented the resident received oxygen therapy while in the facility. During an observation on 11/12/2024 at 11:16 AM, the resident was receiving oxygen at 2 liters via a nasal cannula that was connected to an oxygen concentrator. There was no date on the oxygen tubing when it was changed. During an observation on 11/15/2024 at 3:29 PM, the resident was receiving oxygen at 2 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). The oxygen tubing was dated 11/12/2024. During an observation on 11/18/2024 at 10:11 AM, the resident was not in their room. The oxygen tubing was connected to the oxygen concentrator and was dated 11/18/2024. The Treatment Administration Record dated November 2024, documented the resident received oxygen at 2 liters per minute via nasal cannula (a device that gives additional oxygen through the nose) for chronic respiratory failure. The oxygen tubing (nasal cannula) was to be changed one time weekly and was documented as being changed on 11/08/2024. The Treatment Administration Record dated November 2024, documented the oxygen tubing was last changed on 11/08/2024. There was no documentation on the record that the tubing was changed on 11/12/2024. The Treatment Administration Record dated November 2024, documented the oxygen tubing was last changed on 11/15/2024. There was no documentation on the record that the tubing was changed on 11/18/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/18/2024 at 10:31 AM, Registered Nurse #1 stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift. The surveyor discussed their findings dated 11/12/2024, 11/15/2024, and 11/18/2024. Registered Nurse #1 stated that on 11/12/2024, they made sure the oxygen tubing was dated. When asked if they personally changed the oxygen tubing on 11/12/2024, they stated no, and said it was done on 11/12/2024 during the night shift. They stated when the tubing was changed, it was documented on the Treatment Administration Record. Resident #53 Resident #53 was admitted to the facility with diagnoses of chronic respiratory failure, essential hypertension (high blood pressure), and heart failure. The Minimum Data Set, dated dated dated [DATE] documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions. During an observation on 11/12/2024 at 01:38 PM, the resident received oxygen at 3 liters via a nasal cannula connected to an oxygen concentrator. There was no date on the oxygen tubing. During an observation on 11/15/2024 at 10:22 AM, the resident received oxygen at 3 liters via a nasal cannula connected to an oxygen concentrator. There was no date on the oxygen tubing. During an observation on 11/18/2024 at 10:28 AM, the resident was receiving oxygen at 3 liters via a nasal cannula that was connected to an oxygen concentrator and was dated 11/17/2024. A review of the Treatment Administration Record on 11/15/2024 for November 2024, documented that the resident received oxygen at 3 liters per minute via nasal cannula when placed on the oxygen concentrator. The oxygen tubing (nasal cannula) was to be changed once weekly and was documented as last being changed on 11/10/2024. A review of the Treatment Administration Record on 11/18/2024 for November 2024, documented that the oxygen tubing (nasal cannula) was to be changed on 11/17/2024. During an interview on 11/18/2024 at 10:44 AM, Licensed Practical Nurse #2 stated residents' oxygen tubing was to be changed every Sunday during the overnight 11- 7 shift. They stated they were unsure why the tubing was not labeled as they stated it should have been by the nurse changing it. During an interview on 11/18/2024 at 12:03 PM, Licensed Practical Nurse #3 stated residents' oxygen tubing was to be changed every Sunday during the overnight 11- 7 shift. They stated they were unsure why the tubing was not labeled as they stated it should have been by the nurse changing it. During an interview on 11/19/2024 at 9:50 AM, Registered Nurse #2 stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift. The surveyor discussed their findings dated 11/12/2024, 11/15/2024, and 11/18/2024. Registered Nurse #2 stated that the tubing should have been labeled with the last date changed before the 11/18/2024 date. When asked if the oxygen tubing was changed before 11/18/2024, Registered Nurse #2 stated that they would assume that it was but have no proof as it was not labeled, but stated it was documented on the Treatment Administration Record. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2024 at 11:45 AM, the Director of Nursing #1 stated that nursing staff should be changing the oxygen tubing once a week. They stated that staff should be labeling the oxygen tubing as it was the policy of the facility to do so. Mentioned the labeling observations with the Director of Nursing #1 and they stated that the tubing should not be unlabeled. Resident #68 Resident #68 was admitted to the facility with diagnoses of Sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection that may lead to organ failure or death), Rhabdomyolysis (a serious condition when muscle fibers die and release their contents into your bloodstream), and paroxysmal atrial fibrillation (a condition of having an irregular heartbeat). The Minimum Data Set, dated dated dated [DATE] documented that the resident could be understood and usually understand others and had intact cognition for daily living decisions. During an observation on 11/12/2024 at 12:49 PM, the resident was not receiving oxygen, and a nasal cannula was connected to an oxygen concentrator as well as one attached to the portable oxygen tank in their wheelchair. There were no dates on either oxygen tubing. During an observation on 11/15/2024 at 10:27 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There were no dates on the oxygen tubing. There was no oxygen tubing on the resident concentrator, and it was unplugged. During an observation on 11/18/2024 at 10:12 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There were no dates on the oxygen tubing. There was no oxygen tubing on the resident concentrator, and it was unplugged. A review of the Treatment Administration Record on 11/15/2024 for November 2024, documented that the oxygen tubing (nasal cannula) was to be changed once weekly and was documented as last being changed on 11/10/2024. Staff were to ensure residents' oxygen was in place and functioning every four hours. A review of the Treatment Administration Record on 11/15/2024 for November 2024, documented that Resident #68 was to be on continuous oxygen therapy at 2 liters per minute via a nasal cannula and was to be changed once weekly. The nasal cannula tubing was documented as last being changed on 11/10/2024. The record further documented that staff ensured residents' oxygen was in place and functioning every four hours. The Treatment Administration Record documented that staff was signing off that the resident's oxygen was in place consistently for November 2024 A review of the Treatment Administration Record on 11/18/2024 for November 2024, documented that the oxygen tubing (nasal cannula) was to be changed on 11/17/2024. During an interview on 11/18/2024 at 10:44 AM, Licensed Practical Nurse #2 stated residents' oxygen tubing was to be changed every Sunday during the overnight 11- 7 shift. They stated they were unsure why the tubing was not labeled as they stated it should have been by the nurse changing it. During an interview on 11/18/2024 at 12:03 PM, Licensed Practical Nurse #3 stated residents' oxygen tubing was to be changed every Sunday during the overnight 11- 7 shift. They stated they were unsure why the tubing was not labeled as they stated it should have been by the nurse changing it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2024 at 09:50 AM, Registered Nurse #2 stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift. The surveyor discussed their findings dated 11/12/2024, 11/15/2024, and 11/18/2024. Registered Nurse #2 stated that the tubing should have been labeled with the last date changed before the 11/18/2024 date. When asked if the oxygen tubing was changed before 11/18/2024, Registered Nurse #2 stated that they would assume that it was but have no proof as it was not labeled, but stated it was documented on the Treatment Administration Record. During an interview on 11/19/2024 at 1145 PM, the Director of Nursing #1 stated that nursing staff should be changing the oxygen tubing once a week. They stated that staff should be labeling the oxygen tubing as it was the policy of the facility to do so. Mentioned the labeling observations with the Director of Nursing #1 and they stated that the tubing should not be unlabeled. During an interview on 11/12/2024 at 12:49 AM Resident 68 stated that they only wear the oxygen at night. They mentioned that they came to the facility with oxygen on and the facility had placed it on them but believed they did not require it as they did not wear it at home and had no issues with breathing. During a follow-up interview on 11/18/2024 at 10:12 AM, Resident #68 stated that they were not on oxygen at all over the weekend. They stated they were not sure why there was oxygen as they felt they did not require it. Resident #68 stated that they has never used the portable oxygen tank that is located in their wheelchair. During a follow-up interview on 11/19/2024 at 9:40 AM, Resident #68 stated that they had not been on oxygen much since they have been at the facility. The resident was not on oxygen during their morning physical therapy session. During an interview on 11/19/2024 at 9:50 AM, Registered Nurse #2 stated Resident #68 had an order for oxygen but stated they hardly wore it. They stated that they have had conversations with the team about discontinuing the oxygen for the resident but have not heard from the physician at all. They stated the resident had not been on oxygen for approximately 5-6 days and their oxygen saturation was above 95%. Mentioned findings to Registered Nurse #2 and they verified that the staff have been verifying resident was wearing their oxygen and documenting it in the Treatment Administration Record. They stated that staff should be documenting that the resident was not on oxygen. 10 New York Code of Rules and Regulations 415.12(k)(6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413 Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served in accordance with professional standards for food service safety in 8 of 8 resident unit kitchenettes. Specifically, the area of the resident kitchenettes was not clean, and open containers were not appropriately labeled when they were opened. This is evidenced by: The facility policy titled Area and Equipment Cleaning revised January 2024 documented that the kitchen staff have procedures in place for daily and weekly cleaning of all areas and equipment and documenting on the equipment cleaning log and master cleaning schedule. During an observation on 11/15/2024 at 10:15 AM, the [NAME] 3 unit resident kitchenette toaster had food particles on the catch tray, the counters had food particles on them, the sink area had substance in the basin of the sink, and the microwave shelving unit had food particles on them. None of the areas were appropriately cleaned. Within the refrigerator, there were containers of milk, cranberry juice, and prune juice that were opened with no open date. During an observation on 11/15/2024 at 10:24 AM, the [NAME] 2 unit resident kitchenette juice and coffee machines were covered with dirt and grime and not appropriately cleaned. Within the refrigerator, there were containers of milk, cranberry juice, prune juice, and three containers of blueberries that were opened with no open date. During an observation on 11/15/2024 at 10:48 AM, the Springs 2 unit resident kitchenette juice machine, coffee machine, top of the resident refrigerator, and seals of the resident refrigerator were covered with dirt and grime and not appropriately cleaned. During an observation on 11/15/2024 at 11:00 AM, the Springs 3 unit resident kitchenette juice and coffee machines were covered with dirt and grime and not appropriately cleaned. The resident freezer had significant ice build-up and was not cleaned appropriately. During an observation on 11/15/2024 at 11:08 AM, the Springs 2 unit resident kitchenette juice and coffee machines were covered with dirt and grime and not appropriately cleaned. The resident freezer had significant ice build-up and was not cleaned appropriately. During an observation on 11/15/2024 at 11:21 AM, the [NAME] 2 unit resident kitchenette juice machine, coffee machine, counters, the top of the resident refrigerator, and seals of the freezer and refrigerator were covered with dirt and grime and not appropriately cleaned. Within the resident's refrigerator, a plate of food was not labeled or covered. During an observation on 11/15/2024 at 11:31 AM, the [NAME] 3 unit resident kitchenette juice machine, coffee machine, counters, the top of the resident refrigerator, and seals of the freezer and refrigerator were covered with dirt and grime and not appropriately cleaned. Within the refrigerator, there was a container of milk that was opened with no open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/15/2024 at 11:40 AM, the [NAME] 4 unit resident kitchenette juice machine, coffee machine, counters, the top of the resident refrigerator, and seals of the freezer and refrigerator were covered with dirt and grime and not appropriately cleaned. A review of dining room cleaning logs dated from 11/11/2024 through 11/17/2024 documented that all units were cleaned by staff assigned to that unit. Cleaning logs documented that the inside and tops of juice, ice, and coffee machines were checked off and cleaned by staff. During an interview on 11/15/2024 at 10:10 AM, Nutritional Services Manager #1 stated that the kitchenette food service staff should be cleaning the kitchenettes every day after meal service and signing off when done. They stated that a weekly deep cleaning was performed with audits conducted. In reviewing findings with the Nutritional Services Manager #1 they stated that they were not sure whether it was their responsibility or the housekeeping staff who clean the tops of the machines in the kitchenette areas. They stated that they would have to talk with the Director of Environmental Services and work something out depending on whose responsibility it was. Nutritional Services Manager #1 stated that all items should have an open date on them. They do not necessarily place an expiration date on the fluids as they refer to the best-used date on the packaging. They stated that they do not pour liquids for residents, and it is the nursing staff that performs that task. They stated that they would have to follow up with the nursing department to make sure they place open dates on the items. During an interview on 11/15/2024 at 12:40 PM, Director of Environmental Services #1 stated that they believed it was the Kitchen staff that was responsible for the cleaning of the tops of the machines and refrigerators and not that of the environmental services team. They stated that they did not believe it had been one of the environmental services teams' responsibilities. They stated they would need to have to work out something with the kitchen staff to get them cleaned on a regular basis. 10 New York Codes, Rules, and Regulations 415.14(h)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 48413 Based on observation, record review, and interviews during the recertification survey, the facility did not maintain medical records in accordance with accepted professional standards and practices that were accurately documented and completed for 1 (Resident #68) of 39 residents reviewed. Specifically, for Resident #68 staff was observing and verifying every four hours that the resident's oxygen nasal canula was in place and the resident was using the oxygen as prescribed by the physician. This is evidenced by: A review of the facility policy titled Respiratory Therapy Program dated 4/18/2023 documented the facility was to provide respiratory therapy assessment and treatment to those residents with deficiencies or abnormalities of pulmonary function, for whom a provider's order has been written. Resident #68 was admitted to the facility with diagnoses of sepsis (a life-threatening condition that occurs when the body's immune system has an extreme response to an infection that may lead to organ failure or death), rhabdomyolysis (a serious condition when muscle fibers die and release their contents into your bloodstream), and paroxysmal atrial fibrillation (a condition of having an irregular heartbeat). The Minimum Data Set (an assessment tool) dated 10/23/2024 documented that the resident could be understood and usually understand others and had intact cognition for daily living decisions. During an observation on 11/12/2024 at 12:49 PM, the resident was not receiving oxygen, and a nasal cannula was connected to an oxygen concentrator as well as one attached to the portable oxygen tank in their wheelchair. During an observation on 11/15/2024 at 10:27 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There was no oxygen tubing on the resident concentrator, and it was unplugged. During an observation on 11/18/2024 at 10:12 AM, the resident was not receiving oxygen, and a nasal cannula was connected to the portable oxygen tank in their wheelchair. There was no oxygen tubing on the resident concentrator, and it was unplugged. A review of the Treatment Administration Record on 11/15/2024 for November 2024, documented that Resident #68 was to be on continuous oxygen therapy at 2 liters per minute via a nasal cannula and was to be changed once weekly. The nasal cannula tubing was documented as last being changed on 11/10/2024. The record further documented that staff ensured residents' oxygen was in place and functioning every four hours. The Treatment Administration Record for November 2024 documented from 11/01/2024 through 11/15/2024 that the staff was observing and verifying every four hours that the resident's oxygen nasal canula was in place and the resident was using the oxygen as prescribed by the physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #68 care plans dated 10/17/2024 documented they had the potential for respiratory complications due to prolonged hospitalization , pain, and a new need for oxygen. The care plan further documented the resident to have oxygen administered per the Medical Director's order. A review of the physician order sheet dated 11/01/2024 documented Resident #68 was to be on continuous oxygen at 2 liters per minute via nasal cannula. During an interview on 11/12/2024 at 12:49 AM, Resident #68 stated that they only wore the oxygen at night. They mentioned that they came to the facility with oxygen on and the facility had placed it on them but believed they did not require it as they did not wear it at home and had no issues with breathing. During a follow-up interview on 11/18/2024 at 10:12 AM, Resident #68 stated that they were not on oxygen over the weekend. They stated that they had not been on oxygen in quite some time. They stated they were not sure why there was oxygen as they feel they did not require it. Resident #68 stated that they had never used the portable oxygen tank that was located in their wheelchair. During a follow-up interview on 11/19/2024 at 9:40 AM, Resident #68 stated that they had not been on oxygen much since they had been at the facility. The resident was not on oxygen during their morning physical therapy session. During an interview on 11/19/2024 at 09:50 AM, Registered Nurse #2 stated that Resident #68 had an order for oxygen but stated they hardly wore it. They stated that they have had conversations with the team about discontinuing the oxygen for the resident but have not heard from the physician at all. They stated that the resident had not been on oxygen for approximately 5-6 days and their oxygen saturation was above 95%. Mentioned findings to Registered Nurse #2 and they verified that the staff have been verifying resident is wearing their oxygen and documenting it in the Treatment Administration Record. They stated that staff should be documenting that the resident is not on oxygen. 10 New York Code of Rules and Regulations 483.70 (h)(2)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51742 Based on observations, record review, and interviews during the Recertification Survey, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. Specifically, (a) the facility had an outbreak of COVID 19 that started 7/11/2024 and continued through the survey with 174 (6 admitted w/Covid) resident positives and 100 staff positives and positive residents located in all units throughout the facility; during this time the facility kept COVID negative roommates in the same room with COVID positive roommates, specifically Resident #627 was left in the room with Resident #266 when they were COVID positive, Resident #73 was left in the room with Resident #66 when they were COVID positive, and Resident #55 was left in the room with Resident #265 when they were COVID positive. Resident #627, Resident #73, and Resident #55 all became COVID positive after being left in the room with positive roommates. (b) Doors to COVID positive rooms were kept open with a plastic barricade in front of the door to restrict access. In addition, (c) mechanical lifts were contaminated on 2 Springs, 3 Springs, and 5 Springs units. This is evidenced by: The facility policy titled Infection Control Plan, last revised 11/15/2022, documented that all equipment and surfaces are cleaned and decontaminated after contact with blood or potentially infectious material and when surfaces are overtly contaminated. It further documented that Transmission Based Precautions would be initiated when a resident has a communicable infectious disease. Reusable equipment that is visibly contaminated is not used for the care of another resident until it has been cleaned and disinfected properly. Enhanced Droplet Precautions documented that a private room for infected residents if available, if not cohort the resident with another resident with the same single infection. The door is kept closed and the resident remains in the room. Centers for Medicare and Medicaid Services QSO-20-39-NH, revised 5/8/2023 documented that face coverings were to be used in accordance with CDC guidelines, effective appropriate staff use of personal protective equipment per CDC guidelines, and the core principles that are consistent with CDC guidelines should be adhered to at all times (bold/underlined in QSO). CDC's Infection Control Guidance: SARS-CoV-2 website stated, When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on Droplet Precautions), they should be removed and discarded after the patient care encounter and a new one should be donned. Found at the following website: https://www.cdc.gov/covid/hcp/infection-control/index.html. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 225; Issued 08-08-2024) documents that the infection prevention and control plan must follow accepted national standards and guidelines; it further documents that facilities must implement appropriate use of transmission-based precautions. It documented that a facility should take the appropriate steps to diagnose and manage cases, implement appropriate precautions, and prevent further transmission of the disease. Mechanisms to prevent and control transmission of infectious organisms through direct and indirect contact include standard and transmission-based precautions; for droplet precautions the resident should be placed in a private room, but if a private room was not available, the resident could be cohorted with a resident with the same infectious agent. Resources are available for current recommendations on standard and transmission-based precautions, such as: Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html . (a) Resident #627 and Resident #266 Resident #266 was admitted with diagnoses of diabetes, high cholesterol and hip fracture; the Minimum Data Set (an assessment tool), dated 10/03/2024, documented that the resident had moderately impaired cognition. Resident #627 was admitted with diagnoses of diabetes, high cholesterol and hip fracture. The Minimum Data Set, dated dated [DATE], documented that the resident was cognitively intact. According to the facility line list, Resident #266 tested positive for COVID on 10/21/2024. Resident #627 was negative for COVID on 10/21/2024, but remained in the same room with Resident #266 and Resident #627 became COVID positive on 10/28/2024. Resident #73 and Resident #66 Resident #66 was admitted with diagnoses of dementia, anxiety, and depression. The Minimum Data Set, dated dated dated [DATE], documented that the resident had severely impaired cognition. Resident #73 was admitted with diagnoses of dementia, depression, and high blood pressure.The Minimum Data Set, dated dated dated [DATE], documented that the resident had severely impaired cognition. According to the facility line list, Resident #66 tested positive for COVID on 11/01/2024. Resident #73 was negative for COVID on 11/01/2024, but remained in the same room with Resident #66 and Resident #73 became COVID positive on 11/05/2024. Resident #55 and Resident #265 Resident #265 was admitted with diagnoses of high blood pressure, diabetes, and dementia.The Minimum Data Set, dated dated dated [DATE], documented that the resident had moderately impaired cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #55 was admitted with diagnosis of high blood pressure, dementia, and depression; the Minimum Data Set, dated dated dated [DATE], documented that the resident had severely impaired cognition and could not complete the test. According to the facility line list, Resident #265 tested positive for COVID on 10/30/2024. Resident #55 was negative for COVID on 10/30/2024, but remained in the same room with Resident #265 and Resident #55 became COVID positive on 11/01/2024. During an interview on 11/12/2024 at 3:17 PM, the Infection Preventionist stated that COVID negative roommates were left in the room with COVID positive roommates because they were already exposed to COVID. (b) An observation on 11/13/2024 at 9:39 AM revealed a sign on the ground floor of the Springs Building in front of the elevator that stated masks were required for all staff and visitors. An observation on 3 Springs unit on 11/12/2024 at 11:20 AM revealed that the door to room [ROOM NUMBER] was open and had a COVID sign on a plastic barricade in front of the door, the resident in the room was COVID positive; the door to room [ROOM NUMBER] was open and had a COVID sign on the plastic barricade in front of the door, the resident in the room was COVID positive. An observation on 5 Springs unit on 11/12/2024 at 11:30 AM revealed that the doors to the following rooms with COVID positive residents were open and a plastic barricade was in front of the door: room [ROOM NUMBER], 510, 513, 515, 521, and 523. (c) An observation on 2 Springs unit on 11/12/2024 at 1:47 PM revealed a mechanical lift with a cushion and chunks of unknown brown and yellow material approximately the size of a dime and fluid that appeared sticky and red on the mechanical lift stored between room [ROOM NUMBER] and 206. An observation on 2 Springs unit on 11/13/2024 at 9:41 AM revealed a clean linen storage bin that was uncovered and open. An observation on 2 Springs unit on 11/13/2024 at 10:02 AM revealed a gray mechanical lift observed the prior day in a different position with more chunks of unknown substance on the lift and the top to the cleaning wipes was open to the air. The lift was stored between rooms [ROOM NUMBERS]. An observation on 11/13/2024 at 10:04 AM revealed Certified Nurse Aide #3 walked into a resident room with the surgical mask below the nose; unable to interview the staff member. An observation on 11/13/2024 at 10:19 AM revealed the mechanical lift between room [ROOM NUMBER] and 320 on Springs unit 3 had visible dirt and red sticky substance on the lift and the floor in front of the lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation and interview on 11/15/2024 at 9:54 AM revealed Licensed Practical Nurse #4 donning an N-95 with only 1 strap fastened and a surgical mask on top and entering a COVID isolation room; the nurse said they only had to change the surgical mask and not the N-95. An observation on 11/15/2024 at 10:24 AM revealed a newly placed infection control cart outside of room [ROOM NUMBER] [NAME] without signage to explain which transmission-based precaution. During an interview on 11/19/2024 at 8:15 AM, Infection Preventionist #1 stated that housekeeping was responsible for putting out carts of personal protective equipment and appropriate signage. They also said that staff that used the mechanical lift were responsible for cleaning the lift after each use and when visibly soiled. All staff should ensure the clean linen was covered at all times. Infection Preventionist #1 stated that N-95 masks should only be changed if wet or soiled and not changed after caring for a COVID positive resident, usually they were only changed after each shift, and that they recommended putting a surgical mask over the n-95 and changing that when caring for COVID positive residents. Infection Preventionist #1 stated they were not aware of the CDC guidance requiring removal of the N-95 after caring for a COVID positive resident. The Infection Preventionist stated that roommates of COVID positive residents were already exposed to COVID, so even if they test negative they leave them in the room with the COVID positive roommate and test the negative roommate on days 1, 3 and 5. For staff that test COVID positive at home, the staff member would then drive to the facility to test in the parking lot to confirm the positive result. During an interview on 11/19/2024 at 12:29 PM, Director of Nursing #1 stated that infection control was discussed at all meetings and Infection Preventionist #1 was responsible for following policies and procedures. New York Codes Rules and Regulations 415.19(a)(1-3)