STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335396	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Nursing and Rehabilitation Center	2817 Albany Post Road Montgomery, NY 12549

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, interview, and record review conducted during a recertification survey from 01/07/25 to 01/14/25, the facility did not ensure residents had the right to a dignified experience for 2 of 2 residents (Residents # 65 and Resident # 341) reviewed for dignity. Specifically, 1) Licensed Practical Nurse # 31 was observed standing over Resident # 65 while feeding them their lunch meal and 2) Resident # 341's urine collection bag was observed uncovered and visible to other residents and visitors. The findings include: 1)The facility policy titled Assistance with Meals dated 3/2/24 documented residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity for example, not standing over residents while assisting them with meals. Resident # 65 was admitted to the facility with diagnoses including Cerebral Infarct, Diabetes, and Atrial Fibrillation. The 7/17/23 Comprehensive Care Plan titled Potential for Altered Nutritional Status documented provide necessary encouragement/assist during meals to optimize intake. The 12/4/24 Significant Change Minimum Data Set (an assessment tool) documented Resident # 65 had severely impaired cognition and required staff assistance with eating. During observation on 1/07/25 at 12:13 PM, Registered Nurse # 31 was standing while feeding Resident #65 their meal. During an interview on 1/07/25 at 3:13 PM, Licensed Practical Nurse # 31 stated there were a lot of residents in the room and a small area to feed the resident/s. They stated the resident's chair was large, and although not ideal they did the best they could to feed the resident/s. They stated they should sit down while feeding residents. During an interview on 1/14/25 at 10:14 AM the Director of Nursing stated they needed to emphasize in trainings that feeding residents while standing was not appropriate because residents would like to be fed by staff they could see. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50766 2) Resident # 341 was admitted [DATE] with diagnoses including Iron Deficiency Anemia, Cystitis, and Urinary Tract Infection. The Admission Minimum Data Set, dated dated dated [DATE] documented Resident #341 was cognitively intact and had an indwelling urinary catheter. The Physician Order dated 12/29/24 documented catheter care every shift and as needed. The Care Plan dated 12/29/24 titled Benign Prostatic Hyperplasia/Urinary Retention documented maintain resident dignity at all times. The Care Plan dated 1/5/25 titled Urinary Incontinence and Indwelling Catheter documented catheter care every shift and privacy bag in place whenever resident is out of bed. During an observation on 1/07/25 at 11:08 AM, 1/10/25 at 8:28 AM and 1/13/25 at 9:21 AM Resident #341 was observed lying in bed. The urinary catheter bag was observed without a privacy cover and was visible to other residents and visitors. During an interview on 1/10/25 at 2:04 PM Certified Nurse Assistant #17, stated they were aware the urinary catheter for Resident #341 was not covered with a privacy cover during the morning of 1/7/25 and 1/8/25. They stated the urinary catheter bag privacy cover was attached to the wheelchair. During an interview on 1/13/25 at 2:34 PM Registered Nurse Unit Manager #19, stated there were residents with catheters and Certified Nurse Assistants are educated to cover the catheter bags with privacy covers. They stated they round the unit at least 2-3 times a shift and had observed catheter bags without privacy bags and they re-educated the Certified Nurse Assistant. During an interview on 1/14/25 at 11:17 AM the Administrator stated the facility had a supply of urinary catheter bag privacy covers. They stated the expectation is that urinary catheter bags should be covered for privacy. During an interview on 1/14/25 at 12:20 PM the Director of Nursing, stated urinary catheter privacy covers should always be used for Residents with urinary catheters. They stated nurses and unit managers supervise staff on units and should monitor to ensure that Certified Nurse Assistants were using privacy covers. 10 NYCRR 415.5

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation and interview during the recertification survey conducted from 1/7/25 to 1/14/25, the facility did not ensure a clean and home like environment was maintained for 1 of 2 nursing units (South unit). Specifically, (1) the floor and radiators in room [ROOM NUMBER], #129 and #130 were dirty, the walls and closet trim in room [ROOM NUMBER] had chipped and scuffed paint, room [ROOM NUMBER] had feces on the toilet and room [ROOM NUMBER] had a brown liquid spill on the floor and (2) a meal tray was provided to Resident #24 and contained a hot beverage cup and utensils with a build up of lime deposit stains. The findings include: The policy and procedure titled Cleaning and Disinfection of Environmental Surfaces effective 9/30/2020 last reviewed 3/2024 documented environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. Disinfection (or detergent) solutions will be prepared as needed and replaced with fresh solution frequently (e.g. floor mopping solution will be replaced every three resident rooms, or changed no less than at 60-minute intervals). 1) On 1/7/25 between 10:59 AM and 11:17 AM and 1/10/25 between 12:33 PM and 12:41 PM rooms #128, #129 and #130 on the South unit were observed and had floors that were unclean and radiators that were dirty: room [ROOM NUMBER] walls/ closet trim had chipped and scuffed paint, room [ROOM NUMBER] had feces on the toilet and room [ROOM NUMBER] had a brown liquid spill on the floor. On 01/13/25 at 11:30 AM, during a tour with survey staff, the Director of Housekeeping and Maintenance observed scuffed and chipped paint on the walls and dirty baseboards, floors and radiators in room [ROOM NUMBER], feces on the toilet in room [ROOM NUMBER], and a brown liquid spill mark on the floor in room [ROOM NUMBER]. The Director of Maintenance and Housekeeping stated if the rooms were not cleaned then the housekeeper must not have cleaned them On 01/13/25 at 12:07 PM during an interview, the Director of Housekeeping and Maintenance stated they did not have maintenance and repair logs. They stated the rooms on the South unit were not renovated. The Director of Housekeeping/Maintenance stated they never had a chance to do the repairs in the rooms as they reopened the unit following COVID and they wanted to fill the beds. The Director of Housekeeping and Maintenance stated they did not have a regular schedule for work orders but did rounds every week on Tuesdays and Thursdays. The Director of Housekeeping and Maintenance stated they did not have a log of repairs they made throughout the facility. 50766 2) During an observation on 01/07/25 at 12:25 PM Resident #24's meal with was served on a tray containing a hot beverage cup and utensils with a build up of lime deposit stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 01/13/25 at 03:54 PM the Kitchen Manager stated they observed hot beverage cups and utensils with a build up of lime deposit stains. They stated lime stains built up and left a film on beverage cups and utensils because the facility had hard water. They stated the beverage cups and utensils were supposed to be sprayed, rinsed and scrubbed prior to entering the dishwasher. During an observation and interview on 01/14/25 at 10:29 AM the Director of Food Services stated hot beverage cups and utensils were observed with lime build-up stains. They stated a de-[NAME] product was used for equipment. They stated they tried using de-[NAME] on silver but that caused the silver to tarnish and removed the finish. The Director of Food Services stated a water softener would be of assistance in removing lime scale from beverage cups and utensils. They stated in the past they had discussed the addition of a water softener with Administration and stated the dishwasher repair company also recommended a water softener. During an interview on 01/14/25 at 11:00 AM the facility Administrator stated they believed a water softener addition to prevent lime build up was brought up in the past but was not aware if there had been follow up. They stated the appearance of lime deposit stains on cups, and utensils was not home-like. The Administrator stated the facility recently purchased new cups and utensils, however the lime build-up eventually returned after repeated washing. 10 NYCRR 415.5(h-i)(1-3)

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on record review and interview during the recertification survey from 1/7/25 to 1/14/25, the facility did not ensure that a Level 1 Screen was thoroughly completed prior to admission to the nursing home for 2 of 23 residents (Resident #1 and #30) reviewed for Pre-Admission Screening. Specifically, questions #23 through #27 were left blank on the Level 1 Screen for Resident #1,and questions #27 through #35 were left blank on the Level 1 Screen for Resident #30. The findings include: The facility Policy and Procedure titled PASRR Screening effective 3/2019 last reviewed 3/2024 documented, it is the policy of the facility that all residents must have a PASRR Screen upon admission to this facility and, thereafter, when there is a significant change that has a bearing on the resident's specialized service needs. The screen assesses residents for mental illness, dementia and mental retardation. Resident #1 was admitted to the facility with diagnoses of Cerebral Palsy Seizure Disorder and Dysphagia. The Quarterly Minimum Data Set (assessment tool) dated 10/14/2024, documented Resident #1 was cognitively intact and had unclear speech. There was no documented evidence that questions #23 through #27 were answered on the 6/19/2019 Level I Pre Admission Screen for Resident #1. Resident #30 was admitted with diagnoses of Chronic Obstructive Pulmonary Disease, Insomnia, and Depression. The Prospective Payment System Minimum Data Set, dated dated dated [DATE] documented Resident #30 was cognitively intact, had clear speech and understands/was understood. There was no documented evidence that questions #27 through #35 were answered on the 12/21/2020 Level I Pre Admission Screen for Resident #30. On 1/14/25 at 9:57 AM, the Covering Social Worker stated the Level I Pre Admission Screen for Resident #1 should have been completed thoroughly and acknowledged questions #23 through #27 were blank and acknowledged that Resident #30 had blanks for questions 23 through 35 on the Level I Pre Admission Screen as well. The covering Social Worker stated if audits had been done, they would have identified the incomplete screens. The covering Social Worker stated the Social Worker/s that worked when Resident #1 and #30 were admitted , no longer work at facility. 10 NYCRR415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observation, record review and interview conducted during the recertification survey from 1/7/25 to 1/14/25, the facility did not ensure that the comprehensive person-centered care plan was followed for 1 of 4 residents (Resident #11) reviewed for Accidents. Specifically, for Resident #11, the use of Bilateral Fall Mats were not implemented as per Care Plan after a 10/8/24 fall. The Findings Include: The undated Policy and Procedure titled Accident/Fall Prevention documented a plan of care to prevent falls/injury would be developed. The plan of care would include but not limited to floor mattress, low bed. Each resident would be provided a fall prevention device as needed and the staff would ensure that they were in working order. Resident #11 was admitted with diagnoses including but not limited to Encephalopathy, Dementia, and Chronic Obstructive Pulmonary Disease. The Care Plan titled Risk for Falls effective 10/5/24 last updated 1/5/25 documented an actual fall on 10/8/24, Bilateral Fall Mats. The 5 Day Perspective Payment Minimum Data Set, dated dated dated [DATE] documented Resident #11 had moderately impaired cognition, required substantial to maximum assist with all activities of daily living and had a fall in the last 2-6 months. During observation on 1/7/25 at 9:20 AM, 01/10/25 at 03:45 PM, 01/13/25 at 08:53 AM, and 01/13/25 at 10:02 AM Resident # 11 was resting in bed and did not have Bilateral Fall Mats in place. The 10/9/24-Current Certified Nurse Aide Care Guide documented nonskid socks, Fall Mats at bedside, and bed low. During an interview on 01 /10/25 at 09:16 AM Certified Nurse Aide #13 stated if a resident needed Fall Mats, they would be placed on either side of the bed. During an interview with 01 /10/25 at 01:22 PM Resident #11's daughter, stated they had never seen Fall Mats next to the bed. During an interview on 1/13/25 at 10:32 AM Certified Nurse Aide #13 stated they usually received report in the morning from the night supervisor, and they were not aware the resident should have Fall Mats. They stated they knew the resident so well, so they did not always check the Certified Nurse Aide care guide prior to providing care/s. After reviewing the care guide, Certified Nurse Aide # 13 stated Fall Mats should have been placed when the resident was in bed. They stated since there were no Fall Mats in the room, they were unaware they should have been placed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/13/25 at 10:35 AM Unit Manager #19 stated the staff should check the care guide prior to giving care. They stated the care guide and the care plan included interventions for the use of fall mats. They stated they did not know why the fall mats were not in the room. 10 NYCRR 415.11 (c)(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47626 Based on observation, record review, and interview during the recertification survey conducted 1/07/2025 from 1/14/2025, the facility did not ensure residents who required dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) received services consistent with professional standards of practice for 1 of 1 resident (Resident #68) reviewed for Dialysis. Specifically, there was no documented evidence of consistent assessment and oversight before, during and after dialysis treatment for Resident #68 who received Hemodialysis treatments at a community-based Dialysis Center. Additionally, communication and collaboration between the facility and the Dialysis Center was not consistently documented Findings include: Policy & Procedure titled Hemodialysis dated 3/2019 last reviewed 3/2/2024 documented there will be ongoing communication between the interdisciplinary team and the dialysis center. To ensure exchange of information required to care for the resident is provided through the use of communication book. Book will accompany resident to each dialysis treatment. The Dialysis Book is sent with the resident when the resident travels to dialysis. Important information may include but is not limited to change in vital signs, appetite, labs, wounds, consult, medications, test and behaviors. Resident # 68 with diagnosis of Type 2 Diabetes, End Stage Renal Disease, and History of Cerebral Vascular Accident. The Care Plan titled Renal Failure/Hemodialysis dated 7/25/24 documented exchange information required to care for the resident through use of the Communication Book. Maintain ongoing communication with the Interdisciplinary Team and Dialysis. The Quarterly Minimum Data Set, dated dated dated [DATE] documented Resident #68 had moderately impaired cognition and received dialysis. The January 2025 Physician Order documented: Dialysis on Monday/Wednesday/Friday with a chair time of 10:30 AM and pickup time of 8:30 AM, Assess site for bruising/bleeding/symptoms of infection. Monitor left arm thrill/bruit. Monitor for fluid volume overload. The Facility/Dialysis Center Communication Book revealed the Dialysis Center did not compete their section on 12/9/24, 12/16/24, 12/20/24, 1/6/24, and 1/8/24. The 1/10/25 Pre Dialysis Assessment Communication was not completed by the facility. There was no documented evidence that Post Dialysis Assessments were completed from 12/8/24-1/10/25. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/14/25 at 9:09 AM the Unit Manager #19 stated they communicated with Dialysis via a Communication Book. Unit Manager #19 stated the Medication Nurse was responsible for obtaining resident vital signs and completing the top portion of the form and the Dialysis Center was responsible for completing the middle section. Unit Manager #19 stated the Medication Nurse should have checked the communication book upon the residents return from dialysis and filled out the bottom section. They stated the Medication Nurse should have reported to them any concerns dialysis had. They stated they did not review the Communication Book and were unaware of any issues with the Dialysis Center not completing their section. During an interview on 1/14/25 at 10:00 AM the Director of Nursing stated communication with the Dialysis Center was completed via a form that went back and forth between the facility and the Dialysis Center. The Director of Nursing stated the Medication Nurse should check the Communication Book prior to the resident leaving the facility and should write the resident's vital signs and any changes in the resident's medication. They stated Dialysis Center Staff should complete their section and send the communication book back to the facility. They stated the Medication Nurse should check the book upon its return to the facility. During an interview on 1/14/25 at 11:00 AM Licensed Practical Nurse #20 stated they did not always fill out the post dialysis section in the Dialysis Communication Book. They stated they had to call the Dialysis Center in the past to inform them they did not complete their section in the Communication Book. They stated the forms that did not include a resident name and date were most likely that way due to staff being busy and forgetting to complete the section. During an interview on 1/14/25 at 12:20 PM the Assistant Administrator at Dialysis stated the facility sends a Communication Book back and forth to the Dialysis Center. They stated it would be the responsibility of the Dialysis Nurse to review the Communication Book and complete the Dialysis Center section of the form. They stated they were not aware there was a problem with the information not being communicated as needed. 10NYCRR 415.12(k)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43478 Based on record review and interview conducted during the recertification survey from 1/7/25 to 1/14/25, the facility did not ensure sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not meet minimum staffing requirements for Certified Nurse Aides as documented on the Facility Assessment on 10 of 28 days reviewed. The findings are: The Facility Assessment Staffing Plan Minimum Staffing documented Day shift: 3 Licensed Nurses on both units and 3 Nurse Aides on both units. Evening shift: 2 Licensed Nurses on both units and 3 Nurse Aides on both units. Night shift: 1 Licensed Nurse on both units and 2 Nurse Aides on both units. Actual staffing from December 9 2024 to January 6 2025 documented: 12/14/24 South Unit 11:00 PM-7:00 AM one Certified Nurse Aide, and North Unit 11:00 PM-3:00 AM one Certified Nurse Aide. 12/22/24 North Unit 7:00 PM-9:30 PM two Certified Nurse Aides. 12/25/24 South Unit 7:00 AM-12:00 PM two Certified Nurse Aides. 12/28/24 North Unit 10:00 AM-1:00 PM two Certified Nurse Aides. 12/30/24 North Unit 11:00 PM-4:00 AM one Certified Nurse Aide and South Unit 4:00 AM-7:00 AM one Certified Nurse Aide. 12/31/24 North Unit 11:00 PM-5:30 PM one Certified Nurse Aide and South Unit 11:00 PM-4:15 AM one Certified Nurse Aide. 1/1/25 North Unit 11:00 PM-4:15 AM one Certified Nurse Aide 1/3/25 South Unit 3:00 PM-4:00 PM two Certified Nurse Aides and 10:00 PM-11:00 PM two Certified Nurse Aides. 1/4/25 South Unit 2:30 PM-3:00 PM two Certified Nurse Aides. 1/6/25 South Unit 10:00 PM-11:00 PM two Certified Nurse Aides. During an interview on 1/08/25 at 1:53 PM Certified Nurse Aide #5 stated they came in at 3:00 AM (night shift) on 12/14/24 to assist on the North Unit. They stated they provided care to residents, since there had been only one Certified Nurse Aide working from 11:00 PM until they got there at 3:00 AM. During an interview on 1/08/25 at 2:00 PM Certified Nurse Aide #6 stated they worked with only one other Certified Nurse Aide on the South Unit on 12/25/24 from 7:00 AM to 12:00 PM. They stated each of the Certified Nurse Aides had to stay on one wing to answer call bells and assist residents as best they could. They further stated on 12/28/24 from 10:00 AM until 1:00 PM, they worked with only one other Certified Nurse Aide on the North Unit. They stated it was difficult to keep the residents safe and assist them with cares as needed with only one other Certified Nurse Aide. During an interview on 1/10/25 at 9:05 AM Certified Nurse Aide #10, stated on 1/3/25 they worked with only one other Certified Nurse Aide from 3:00 PM to 4:00 PM and from 10:00 PM to 11:00 PM. They stated on 1/6/25 they worked with only one other Certified Nurse Aide on the South Unit from 10:00 PM to 11:00 PM. They stated it was challenging to meet resident needs, keep residents safe, and assist with toileting when they were short staffed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/10/25 at 9:09 AM Certified Nurse Aide #8 stated on 12/30/24 they came in at 4:15 AM and were the only Certified Nurse Aide on the unit. They stated they completed as many cares as possible to try to meet all the resident's needs. Certified Nurse Aide #8 stated in order to meet all resident needs, it was much better to work with two Certified Nurse Aides. During an interview on 1/10/25 at 9:16 AM Certified Nurse Aide #7 stated on 12/22/24 they worked with only one other Certified Nurse Aide from 7:00 PM to 9:30 PM. They stated it was difficult getting residents ready for bed. They stated on 1/4/25 they worked with only one other Certified Nurse Aide from 2:30 PM to 3:00 PM. They stated it was always hard when working with only one other Certified Nurse Aide. During an interview on 1/13/25 at 8:49 AM Certified Nurse Aide #4 stated on 12/14/24 they were the only Certified Nurse Aide on the unit from 11:00 PM to 3:00 AM, on 12/31/24 they were the only Certified Nurse Aide on the unit from 11:00 PM to 5:30 AM, and on 1/1/25 they were the only Certified Nurse Aide on the unit from 11:00 PM to 4:15 AM. They stated they tried to do the best they could, but it was impossible to take care of approximately 40 residents and answer the call bells timely. They stated they completed what they could, but it was hard. During an interview on 1/13/25 at 9:16 AM Certified Nurse Aide #18 stated on 12/31/24 they were the only Certified Nurse Aide on the unit from 11:00PM to 4:15 AM. They stated it was not easy to provide care to so many residents by themselves. They stated they changed as many residents and answered as many call bells as they could. During an interview on 1/13/25 at 9:40 AM the Staffing Coordinator reviewed the Staffing Plan Minimum Staffing documented in the Facility Assessment and reviewed the actual staffing from December 9 2024 to January 6 2025 and stated they were aware the facility did not meet the minimum staffing numbers for Certified Nurse Aides on 10 of 28 days reviewed. They stated last minute callouts had been a problem. On 01/13/25 at 10:53 AM during an interview with the facility Administrator, they stated they are aware that the facility did not meet the minimum staffing numbers of Certified Nurse Aides on multiple days reviewed. They stated they were meeting with the union regarding issues with callouts, they already implemented a gift package for the Employee of the Month, they wanted to implement a bonus for attendance and needed to speak with Corporate about it. 10 NYCRR 415.13(a)(1) (i-iii)

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NAME OF PROVIDER OR SUPPLIER: Montgomery Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2817 Albany Post Road Montgomery, NY 12549	

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43478 Based on record review and interview during the recertification survey from 1/7/25 to 1/14/25, the facility did not ensure Certified Nurse Aide performance appraisals were completed at least once every 12 months for 5 of 5 Certified Nurse Aides reviewed. Specifically, performance appraisals were not documented every 12 months for Certified Nurse Aides #1, #2, #3, #4, and #5. The findings are: There was no documented evidence that performance appraisals were completed every 12 months for Certified Nurse Aide #1, #2, #3, #4 and #5. During an interview on 1/08/25 at 9:25 AM the Director of Nursing stated they were aware that performance appraisals should be completed for the Certified Nurse Aides and stated they were responsible for writing the performance appraisals. 10 NYCRR 415.12(h)(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41666 Based on observation, record review, and interview conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure a medication error rate of no more than 5%, 2 of 35 opportunities (5. 71%) for 2 of 4 residents (Resident #34 and Resident #31) reviewed for Medication Administration. Specifically, 1) Resident #34 was administered one Tums 200 mg/ Calcium 500 mg chewable tablet instead of two as per physician order, and 2) Resident #31 did not receive Vitamin C as per physician order. The findings include: The Policy titled Medication Administration dated [DATE] documented medications would be administered to residents in a timely and accurate manner by a licensed nurse or physician. Resident #34 was admitted to the facility with diagnoses including but not limited to Atrial Fibrillation, Dysphagia and Hypertension. The [DATE] Physician Order documented Tums 200 mg/Calcium 500 mg chewable tablet, give 2 by oral route for heartburn. During the [DATE] at 9:40 AM medication administration observation Licensed Practical Nurse #21 removed one tablet of Tums 200 mg/Calcium 500 mg chewable tablet from the bottle and administered it to Resident #35. During an interview on [DATE] at 12;49 PM Licensed Practical Nurse #21 stated they did not realize they needed to administer two Tums 200 mg/Calcium 500 mg chewable tablets, and should have read the order more closely. Resident # 31 was admitted with diagnoses including but not limited to Atrial Fibrillation, Congestive Heart Failure and Pleural Effusion. The [DATE] Physician Order documented Vitamin C 500 mg tab, two tablets every day. During the [DATE] at 10:00 AM medication administration observation Vitamin C was not administered. The Medication Administration Record documented Vitamin C was signed off by the Licensed Practical Nurse #20 on [DATE] as administered at 9:00 AM. During an interview on [DATE] at 11:15 AM Licensed Practical Nurse #20 stated they gave the Vitamin C during the medication pass. Licensed Practical Nurse #20 then stated the Vitamin C bottle was expired, they needed to get a new bottle. When asked why they signed for the Vitamin C before they administered the Vitamin C, they stated they accidentally signed off. During an interview on [DATE] at 11:56 AM the Director of Nursing stated medications needed to be given as prescribed by the physician. They stated the nurses needed to do better. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.12(m)(1)

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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** 50766 Based on observation and interview conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure food was stored in accordance with professional standards for food service safety. Specifically, 1. the refrigerators contained food and/or packages that were unlabeled, had no received on date, and did not contain an expiration date, 2. the walk-in freezer contained food and/or packages that were unlabeled and not properly sealed to prevent freezer burn, and 3. the dry storage pantry contained food products that did not contain expiration dates. The findings are: During an initial tour of the kitchen on [DATE] at 09:52 AM accompanied by the Director of Food Services, the following was observed in the food service refrigerators/walk in freezer and dry storage area: The Refrigerator contained: -Six 80 individual slice packs of American Cheese with no expiration date -One unlabeled container of beef meatballs -Three and one-half trays of eggs with no received date and no expiration date -One unlabeled/undated container of thawed chicken thighs -One four-pound jar of grape jelly with no expiration date The Walk in Freezer contained: -One open box of sausage patties was not covered to protect from freezer burn. -One five-pound bag of French fries with no expiration date. -One unlabeled opened bag of tater tots -One opened bag of meatballs with no open on date and no expiration date. The Dry Storage Area, contained: - One four pound can of tuna with no expiration date. - One can of spaghetti sauce with no expiration date. - One gallon bottle of Sweet and Sour Sauce with no expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Four boxes of individual size oat meal pies with no expiration date. -One box of approximately 30 individual packs of graham crackers with no expiration date. -One 16-ounce bottle of Curry Powder with no expiration date. -One 16-ounce jar of Chicken Paste with no expiration date. -One 13-ounce Classic [NAME] Gravy packet with no expiration date. -One 10-pound bag of dry pasta with no expiration date. During an interview on [DATE] at 9:52 AM the Director of Food Services stated kitchen staff was trying not to have as many boxes in the refrigerator, freezer, and dry storage area and that the discarded boxes may have contained expiration dates for the products. They stated they would discuss why canned and packaged goods did not have individual expiration dates with the food supplier. The Director of Food Services stated kitchen staff were expected to label and date all products in the kitchen and the facility received weekly deliveries of food products, therefore no products should be expired. 10NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43478 Based on observation, record review, and interview during the recertification survey from 1/7/25 to 1/14/25, the facility did not ensure infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection was maintained for 2 of 8 residents (#49, and #66) reviewed for Infection Control. Specifically, 1) the facility did not properly implement transmission-based precautions for Resident #49 and 2) the facility did not ensure an infection surveillance plan was implemented for identifying, tracking, and monitoring infections, communicable diseases, and outbreaks for Resident #49 and # 66, The findings are: The Policy titled Transmission-Based Precaution last updated 7/8/20/24 documented transmission- based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases of infections that can be transmitted to others. Droplet precautions are to be implemented for residents known to be infected with microorganisms that can be transmitted by droplets which includes Coronavirus. Contact precautions should be implemented for residents infected with microorganisms that can be transmitted by direct contact which includes diarrhea associated with colostrum difficile, and the resident should be placed in a private room if it is not feasible to contain drainage excretions and blood or body fluids. Enhanced barrier precautions should be implemented for residents with wounds. The Policy titled Infection Control last updated 11/12/24 documented that to prevent, detect, and control infections within the nursing home the facility will develop and maintain a surveillance program to prevent and control infections within the facility with its purpose to detect and record nosocomial infections to institute effective control measures, including to record data of infections on resident's surveillance reports and infection line listing reports. Resident #49 was positive for Colostrum Difficile (inflammation of the colon caused by bacteria) on 10/18/24. During observation on 1/7/25 at 3:09 PM, there was no Contact Precaution sign on the door and 1/08/25 at 9:35 AM, there was no personal protective equipment or Contact Precaution sign outside Resident #49's room. During an interview on 1/13/25 at 1:16 PM, Housekeeper #34 was observed in Resident #49's room wearing gloves and without a gown. Housekeeper # 34 was squatting down while cleaning the molding and the floor. Housekeeper #34 removed their gloves, and left the room without performing hand hygiene. During an interview at that time, Housekeeper #34 stated they did not wash their hands with soap and water and did not know they should have worn a gown. Duirng an interview on 1/13/25 at 2:04 PM the Director of Nursing stated the Physician Order for Resident #49's Contact Precautions was renewed on 1/5/25. The Director of Nursing stated a sign for Contact Precautions should have been posted on Resident #49's door. The Director of Nursing stated for a resident with Colostrum Difficile, staff and visitors should be alerted to wear a gown and gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 1/13/25 at 2:04 PM the Director of Nursing stated they could not provide tracking and prevention purposes regarding the number of residents who currently had urinary tract infections because the information was not documented in one centralized document tool. The Director of Nursing stated they did not keep an updated record in real time to identify clusters of infections and to prevent the spread of infections for residents on precautions, residents who had infection, residents who had signs and symptoms of infection, and residents on antibiotics. During an interview on 1/13/25 at 2:35 PM the Director of Nursing Resident #49 who had a diagnosis of Colostrum Difficile was not included on the November 2024 or the December 2024 tool for infections. They stated on November 5th, Resident #49 went to the Infectious disease physician for recurrent infection, and a recommendation to taper off antibiotics was made, but when the antibiotic Vancomycin was re-started on 11/20/24, they did not enter Resident #49 onto the tool to document infections but stated they should have done so. During an interview on 1/14/25 at 10:25 AM the Director of Nursing stated Resident #66 who had a diagnosis of a chronic urinary tract infection, was not included on the December 2024 or January 2025 tool for infections. They stated Resident #66 was on standing antibiotic Macrodantin since 4/24/2023 and should be listed on the tool to document infections. 10NYCRR 415.19(a)(2) 41666 50766

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45478 Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00359070) from 1/7/2025 to 1/14/2024, the facility did not ensure that an effective pest control program was maintained so that the facility was free of rodents on 1 of 2 units (South) and the physical therapy department. Specifically, there was no documented evidence of facility follow up/monitoring to assess ongoing need and/or effectiveness of interventions put in place by the pest control company to eradicate and/or contain mice. The findings are: The policy and procedure effective 3/2019 last reviewed 3/2024 titled Pest Control documented this facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. The Pest Control Logbook dated 2/7/24 to 1/8/25 documented mice were observed in room [ROOM NUMBER] and #106 on 4/16/24, a mole was observed in room [ROOM NUMBER], and maintenance shop on 10/15/24, a mouse was in room [ROOM NUMBER] on 10/15/24, and a mouse was in the therapy room on 11/3/24. The 4/17/24 Service Inspection Report documented mice were in room [ROOM NUMBER] and room [ROOM NUMBER]. Ready to use glue boards were placed in each room. No other reports. Inspected and treated all nursing stations, common areas and kitchen. The 10/16/24 Service Inspection Report documented treated all nursing stations in common areas and kitchen for general pest prevention. Check all ready to use monitors and tincats. One mouse caught on the glueboard near the exit door under ventilation. Replenished all monitors. The 11/13/24 Service Inspection Report documented light activity in the therapy department. Inspected and treated the entire interior and exterior for all pest and rodent activity including all common areas, nursing stations and kitchen. Replenished all bait stations throughout the facility interior and exterior. During observation on 1/07/25 at 11:17 AM, room # 131/Resident #54 was observed to have a mouse trap behind the dresser and located under the radiator. It was also observed that Resident #54 had an open box of donuts on the dresser and extra food items in the room. During interview on 1/13/25 at 3:53 PM, the Director of Rehabilitation stated they did not actually see mice, but they saw mice droppings in the physical therapy department. They stated they alerted the head of maintenance and they called the pest control company who sprayed all along the baseboards and put a mouse trap in the room.They stated the mouse trap was no longer in place. During interview on 1/14/25 at 9:13 AM, Licensed Practical Nurse #14 stated they did not recall seeing or hearing about mice in April of 2024. Licensed Practical Nurse #14 stated if a Certified Nurse Aide saw a mouse they would verbally report it to maintenance. Licensed Practical Nurse #14 stated they did not have maintenance repair/housekeeping logs on the units where they would report concerns for maintenance/housekeeping such as mice. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/14/25 at 9:47 AM, the Director of Maintenance/Housekeeping stated when there were reports of mice, they had pest control company place mouse traps. The Director of Maintenance/Housekeeping stated they knew traps were placed but, a review of reports to determine if the traps were working/rounds to check for mice was not done. The Director of Maintenance/Housekeeping stated they had no documentation of their follow regarding the issue. The Director of Maintenance/Housekeeping stated they felt it was being taken care of by having the mouse traps. The Director of Maintenance/Housekeeping stated the pest control company checked the traps to see if there were mice in them. The Director of Maintenance/Housekeeping stated they were not informed of any mice being found in the mouse traps. 10 NYCRR 415.29(j)(5)