

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Orchard Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Bates Road Medina, NY 14103	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43785</p> <p>Based on observation, interview, and record review conducted during a Standard survey completed on 4/16/2024, the facility did not ensure that the residents' environment remained as free from accident hazards as possible, and each resident receives adequate supervision for one (Resident #116) of one resident reviewed. Specifically, the facility did not</p> <p>implement their smoking policy to ensure that comprehensive quarterly assessments were completely to ensure safe smoking practices. Additionally, the was no compressive care plan developed for smoking.</p> <p>The finding is:</p> <p>The policy and procedure titled Smoking Policy, dated 10/2017, documented all residents that express a desire to smoke will have a smoking assessment completed to determine their safety and physical ability to smoke. This assessment will be completed on admission, readmission, quarterly and as needed. The policy and procedure further documented residents who are determined to smoke independently, will be required to surrender all smoking materials to staff and residents' preferences to smoke will be included in their plan of care.</p> <p>Resident #116 had diagnoses that included diabetes mellitus (high blood sugar), glaucoma (group of eye diseases that can cause vision loss) and chronic obstructive pulmonary disease (lung diseases that blocks airflow and makes it difficult to breath). The Minimum Data Set (a resident assessment tool) dated 1/23/2024 documented Resident #116 was understood, understands and was cognitively intact.</p> <p>Review of the Care Plan dated prior to 4/11/2024 revealed there was no documented evidence Resident #116 was a current smoker.</p> <p>The hospital Discharge Summary dated 9/20/2022 documented Resident #116 had current tobacco abuse.</p> <p>The facility Admission History and Physical dated 9/23/2022 documented Resident #116 had chronic obstructive pulmonary disease, tobacco abuse and current tobacco history.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Interdisciplinary Team Meeting Summary of Minutes dated 8/2023 documented Resident #116 verbalized their desire to smoke and refused smoking cessation. The resident was cognitively intact and had verbalized that they would surrender all smoking paraphernalia to administration and that they would request all smoking paraphernalia and cigarettes if they desired to smoke. The resident agreed to surrender all smoking paraphernalia to be stored and locked up, safety considerations were thoroughly discussed, and the meeting concluded with a reaffirmation of the team's commitment to promote resident autonomy while ensuring the safety and wellbeing of all residents and staff.</p> <p>Review of the electronic medical record revealed there was no documented resident smoking assessments from 9/20/2022 through 4/10/2024.</p> <p>Review of the Smoking Group Times list dated 2/28/2024 provided by the facility revealed there was no documented evidence that Resident #116 smoked.</p> <p>During an interview on 4/10/2024 at 8:33 AM, Licensed Practical Nurse #2 stated Resident #116 smokes, and the resident goes outside to smoke.</p> <p>During an interview on 4/09/2024 at 10:14 AM, Resident #116 stated that they smoke, and they go outside to smoke independently. Resident #116 stated they have cigarettes locked up in the facility and may have some in their room.</p> <p>During an observation on 4/11/2024 at 11:32 AM Resident #116 was observed outside sitting in a wheelchair near the facility conference room window taking a lighter and cigarette from their pocket and smoking.</p> <p>During an interview on 4/11/2024 at 2:08 PM, Activity Aide #1 stated they help the residents go out who want to smoke. Only the residents that were on the smoking list can go out and smoke. Resident #116 was not on the list but had seen Resident #116 outside smoking in front of the building. Residents who smoke were not allowed to hold or have their cigarettes and lighter on them or in their rooms. We hold and lock up all smoking materials.</p> <p>During an interview on 4/11/24 at 2:25 PM, the Director of Activities stated they were familiar with Resident #116 and the resident was not on the smoking list. Residents who smoke currently were grandfathered and on the list that started January of 2023. The facility does not admit residents that smokes since then. There was a designated smoking area out back and activities staff oversee the residents who smoke. The Director of Activities also stated they have seen Resident #116 smoke in front of the building, and it has been brought to the Administrator's attention but was unsure what was done about it. Nursing was responsible for care planning and completing smoking assessments. They were unsure if Resident #116 was assessed in the past or if they were care planned for smoking.</p> <p>During an interview on 4/12/2024 at 8:52 AM, Licensed Practical Nurse, Unit Manager #6 stated they were aware that Resident #116 smoked and had talked about it with other staff and brought up to management. They were unsure why Resident #116 was never assessed, or care planned for smoking.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/12/2024 at 11:19 AM with the Director of Nursing and the Administrator, the Director of Nursing stated they were aware Resident #116 smoked in the past and the resident had unsupervised out on pass privileges. The Administrator stated they were aware Resident #116 smoked and had a conversation with the resident in August of 2023 when the resident was caught smoking outside on the property.</p> <p>During an interview on 4/16/2024 at 10:33 AM with the Administrator and the Director of Nursing, the Administrator both stated Resident #116 should have been assessed for smoking and the care plan should have been updated to include smoking back in August of 2023.</p> <p>10 NYCRR 415.12(h)(1)</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785</p> <p>Based on interview and record review conducted during a Standard survey completed [DATE], the facility did not ensure any individual working in the facility as a nurse aide for more than 4 months was competent to provide nursing and nursing related services for one of five staff (Resident Assistant #1) reviewed for training. Specifically, Resident Assistant #1 functioned in the role of a nurse aide for greater than 4 months without receiving nurse aide certification.</p> <p>The finding is:</p> <p>The Centers for Medicare and Medicaid Services published guidance for expiration of the COVID-19 public health emergency (QSO-,d+[DATE]-ALL), dated [DATE], documented that previously Centers for Medicare and Medicaid services had waived the requirement that the facility may not employ anyone for longer than four months unless they met training and certification requirements. QSO-,d+[DATE]-ALL documented that all individual waivers granted would expire prior to the end of the public health emergency and the uncertified nurse aides working in a long-term facility would have four months from the date of the public health emergency ending to complete a state approved Nurse Aide Training and Competency Evaluation Program.</p> <p>Review of the facility policy and procedure titled Nurse Aide Training Program dated [DATE], documented that if the individual has not passed the certification examination within the three attempts and/or within 120 days of their first day of training or employment, the individual may no longer work as a nurse aide trainee in the nursing home. The policy and procedure documented the nurse aide trainee was required to work under direct supervision of certified and licensed staff. The facility policy and procedure documented the facility may assign the individual to nonresident contact duties.</p> <p>Review of the facility's Employee Status Change form dated [DATE] documented Resident Assistant #1 transitioned from the dietary department to Certified Nursing Assistant-online certificate.</p> <p>Review of a vocational school certificate documented that on [DATE] Resident Assistant #1 had completed a 48-hour temporary Nurse Aide to Certified Nurse Aide training program.</p> <p>Review of the New York State Nurse Aide Registry on [DATE] documented Resident Assistant #1 was not found.</p> <p>(continued on next page)</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:09 PM, Resident Assistant #1 stated they were a Certified Nursing Assistant with the facility, but they did not receive their New York State Certified Nursing Assistant certificate. They stated they last took the New York State certification exam in March of 2024 but was not successful in passing. Resident Assistant #1 stated that they had completed their nurse aide training course in [DATE] at a vocational school. Resident Assistant #1 stated they first started working at the facility as a dietary aide and was unsure of the date when they transitioned into the Certified Nursing Assistant position. Resident Assistant #1 stated they usually worked 2:00 PM- 6:00 AM six days a week and performed all certified nursing assistant duties for the residents. Resident Assistant #1 stated some examples of their duties were hands-on-care, toileting, activities of daily living, and feeding residents. Resident Assistant #1 stated they worked independently as long as the resident was only a one-assist level of care. Resident Assistant #1 stated that if a resident was a two-assist level of care then they would get another staff member. Resident Assistant #1 stated that no other staff member needed to directly oversee the care they provided to the residents.</p> <p>During a telephone interview on [DATE] at 8:31 AM, Licensed Practical Nurse #4 stated that they have worked the overnight shift with Resident Aide #1. Licensed Practical Nurse #4 stated that Resident Aide #1 was able to perform certified nursing assistant duties independently and they did not need to be directly supervised when job duties were performed.</p> <p>During an interview on [DATE] at 9:01 AM, Licensed Practical Nurse #3 stated they were the unit manager for Unit one and that Resident Aide #1 worked as a certified nursing assistant on their unit during the overnight shift. Licensed Practical Nurse #3 stated that Resident Aide #1 was able to care for residents independently when the resident was a one-staff level of assistance without direct supervision.</p> <p>During an interview on [DATE] at 10:48 AM, the Director of Human Resources, stated that the independent skills evaluator/nurse aide evaluator testing forum was not holding the certified nursing assistant exam for two years during the COVID-19 pandemic, and that the Resident Assistants worked on the floor temporarily and were allowed to do resident care with the supervision of a certified nursing assistant. The Director of Human Resources stated until the resident assistant passed the exam, they were to be supervised by another certified nursing assistant. The Director of Human Resources stated that if the Resident Assistant failed the exam, they would have to retake the test within four months after completion of the class. The Director of Human Resources stated the Resident Assistant #1 took their Nurse Aide Training course at a vocational school. The Director of Human Resources stated that Resident Assistant #1 had successfully completed the clinical skills portion of the certification examination but had not successfully completed the academic portion of the certification exam.</p> <p>(continued on next page)</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 12:01 PM, with the Administrator and the Director of Nursing, the Director of Nursing stated that Resident Aide #1 started working at the facility in 2014 as a dietary aide and transitioned into the Nurse Aide Training Program on [DATE]. The Director of Nursing stated that Resident Aide #1 had three unsuccessful attempts at passing the New York State Certified Nursing Assistant exam but was unaware of the dates Resident Aide #1 took the exam. The Director of Nursing stated that Resident Aide #1 performed duties that a certified nursing assistant performed. The Director of Nursing stated they were following the New York State Department of Health DAL letter from [DATE] and they were under the impression that a training nurse assistant could still perform certified nursing assistant duties past four months of completing the nurse aide training program. The Director of Nursing stated they were aware that all COVID-19 waivers had expired. The Director of Nursing stated that they cannot say that Resident Assistant #1 never performed certified nursing assistant duties on their own and they had never instructed Resident Assistant #1 that they needed to work in visual supervision with another staff member. The Director of Nursing stated that on [DATE], Resident Aide #1 was instructed that they could only perform resident assistant duties which included they were not to provide any hands-on care to residents. The Director of Nursing stated that the importance of being certified as a certified nursing assistant was that the staff member had tested and proven they understood the position of a certified nursing assistant. The Administrator stated their agreement with what the Director of Nursing had stated.</p> <p>During an interview on [DATE] at 12:54 PM, the Administrator stated they could not provide documented evidence of the dates when Resident Assistant #1 took the New York Certified Nursing Assistant exams. The Administrator stated that per their interview with Resident Assistant #1, Resident Assistant #1 was scheduled to take the exams on the following dates:</p> <ul style="list-style-type: none"> - [DATE], was unsuccessful in passing the exam - [DATE], passed the skills test, unsuccessful with the written portion of the test - [DATE], did not show up for the exam - [DATE], the independent skills evaluator/nurse aide evaluator testing forum did not provide proper testing accommodations as requested. <p>10NYCRR 415.26(d)(2)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>43785</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 4/16/24, the facility did not provide food and drink that was at a safe and appetizing temperature for four (Main Dining Room, Unit 1, Unit 2, and Unit 3) of four test trays. Specifically, food and beverages during meals were served at suboptimal temperatures. Residents #85, #74, #51, #4, and #1, were involved.</p> <p>The findings are:</p> <p>The policy and procedure titled Dietary Food Preparation and Service dated 5/2/23, documented that food and nutrition service employees prepare and serve food in a manner that complies with safe food handling practices. The danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes for the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, potentially hazardous foods must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit.</p> <p>The Dietary Food Committee Meeting minutes dated 4/3/24 documented that 3 of 7 residents had complained that food was served cold.</p> <p>During an interview on 4/9/24 at 9:44 AM, Resident #85 stated that hot foods were not served hot, and cold foods were not served cold. The food needed improvement and they had spoken to the dietician about their complaints.</p> <p>During an interview on 4/9/24 at 10:04 AM, Resident #74 stated the food was usually served very cold and served late recently.</p> <p>During an interview on 4/9/24 at 12:04 PM, Resident #51 stated they had recently started to have breakfast and lunch in the main dining room as food was usually served warm in the main dining room, but it wasn't warm when served on the unit in residents' rooms.</p> <p>During an interview on 4/9/24 at 3:17 PM, Resident #4 stated the food was not served warm enough, it was lukewarm when delivered to their room and they ate all their meals in their room.</p> <p>During a telephone interview on 4/10/24 at 10:30 AM, the interim Ombudsman stated that they had received complaints from residents that when they ate in their rooms their meals were late, the hot foods were cold, and the cold foods were warm. The Ombudsman stated the facility no longer used the hot plates that were placed under the food plates that kept the food warm. The Ombudsman stated they did not have resident specific names that filed the complaints.</p> <p>During a lunch meal tray observation on 4/11/24 all the residents in the main dining room had been served their meals by 12:04 PM. At 12:05 PM the test tray temperatures were taken by the Food Service Director using the facility's digital thermometer. The results were as follows:</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> - Chicken and biscuits measured 122.9 degrees Fahrenheit, tasted cold and was salty. - Mixed vegetables measured 116.8 degrees Fahrenheit, tasted cold and had no flavor. - Apple juice 57.5 measured degrees Fahrenheit, tasted warm and was unappetizing. - 2 % (percent) milk measured 55.2 degrees Fahrenheit, tasted warm and was unappetizing. <p>During an interview on 4/11/24 at 12:19 PM, the Food Service Director stated hot foods should be above 140 degrees Fahrenheit and cold drinks should be below 38 degrees Fahrenheit. The food could have been warmer.</p> <p>During a lunch meal tray line observation on 4/11/24, the unit carts left the kitchen at the following times: Unit 3 cart at 12:19 PM, Unit 1 and 2 carts at 12:44 PM. The lunch meals were plated and covered, there were no insulated bases.</p> <p>During a lunch meal tray observation on 4/11/24 at 12:22 PM, the Unit 3 dietary cart arrived at 12:21 PM and meal trays were all passed by 12:29 PM. A test tray was completed with the Food Service Director at 12:30 PM for temperatures and palpability. The temperatures were taken by the Food Service Director using the facility's digital thermometer. The results were as followed:</p> <ul style="list-style-type: none"> - Chicken and biscuits measured 120.1 degrees Fahrenheit were slightly warm and very salty - Mixed vegetables measured 108 degrees Fahrenheit, tasted bland and were soft. - Apple juice measured 50.8 degrees Fahrenheit and tasted warm - 2 % milk measured 47 degrees Fahrenheit and tasted warm. <p>During a lunch meal observation on 4/11/24, the Unit 1 first dietary cart arrived on the unit at 12:27 PM. The Unit 1 second dietary cart arrived at 12:35 PM and third cart arrived at 12:45 PM. All the meal trays were passed to the residents by staff at 12:49 PM. A test tray was completed for temperatures and palatability with the Food Service Director at 12:49 PM using the facility's digital thermometer. The results were as follows:</p> <ul style="list-style-type: none"> - Chicken with gravy over biscuits measured 126 degrees Fahrenheit and tasted cold - Mixed vegetables measured 132 degrees Fahrenheit and tasted cool - Cranberry juice measured 56 degrees Fahrenheit and tasted lukewarm - Milk measured 54.6 degrees Fahrenheit, tasted warm and was not palatable <p>During an interview on 4/11/24 at the time of test tray, the Food Service Director stated that safe food temperatures should be that cold foods were to be served below 40 degrees Fahrenheit, and that hot food were to be served at 140 degrees Fahrenheit or above. The Food Service Director stated after tasting for food for palatability that the cranberry juice could be colder and that if they drank milk they would like it colder. The Food Service Director stated the hot foods could be warmer.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a lunch meal tray observation on 4/11/24, the Unit 2 first dietary cart arrived on the unit at 12:32 PM, staff completed the first cart tray pass at 12:40 PM. The Unit 2 second dietary cart arrived at 12:43 PM and third cart arrived at 12:46 PM. The staff completed the entire tray pass by 12:49 PM. Test tray temperatures were obtained at 12:49 PM with the Dietary Aide #1 using the facility's digital thermometer. The results were as follows:</p> <ul style="list-style-type: none"> - Mixed vegetables measured 107.2 degrees Fahrenheit and tasted cold - Apple juice measured 60.1 degrees Fahrenheit and tasted warm - Milk 57.4 measured degrees Fahrenheit, tasted warm and was not palatable <p>During an interview on 4/11/24 at 12:56 PM, Dietary Aide #1 stated the food was cooked to over 165 degrees Fahrenheit and hot foods should be served over 140 degrees Fahrenheit and cold items should be below 40 degrees Fahrenheit. Dietary Aide #1 stated this was done so nobody got sick. Dietary Aide #1 stated they attended the resident food council meetings and there were a few complaints about cold food at the most recent meeting.</p> <p>During an interview on 4/11/24 at 12:58 PM, Resident #1 stated the lunch meal tasted alright, but their meal was cold, and their drinks were warm. Resident #1 stated that their breakfast and lunch meals were always served cold, and the Certified Nursing Assistants always had to heat up their meal in the microwave. Resident #1 stated they would not eat their meal until it was re-heated.</p> <p>During an interview on 4/11/24 at 1:00 PM, Certified Nursing Assistant #3 stated that when they serve residents eating breakfast and lunch trays in their rooms the hot foods were always cold. They stated that the dietary department no longer uses the hot plates, and they had to re-heat up the meals in the microwave so the residents can have a hot meal.</p> <p>During an interview on 4/16/24 at 10:25 AM, the Director of Nursing stated that their expectation for proper cold/hot foods temperatures were to follow the facility policy. They stated the importance of serving food at safe food temperatures were for pleasure, to keep residents free from injury, and to prevent food-borne illness.</p> <p>10 NYCRR 415.14(d) (1) (2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785</p> <p>Based on observation, interview, and record review conducted during a Standard survey completed on [DATE], the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, three (Unit 1, Unit 2, and Unit 3) of three-unit nourishment refrigerators, one of one main kitchen, and one (Main dining room and Unit 3 Dining Room) of two serveries observed had issues. The nourishment room refrigerators contained undated, unlabeled, and out of date food and drink items. The kitchen had a greasy oven door, the splatter guard behind the stove was heavily soiled with dried brown/black grease; a commercial coffee maker and its carafes were heavily soiled with coffee stains, and there was a rusty and dusty desk fan under the tray line. In addition, the cook was observed in the main dining room not following proper hand hygiene while serving a meal.</p> <p>The findings are:</p> <p>The policy and procedure titled Proper Food and Drink Storage and Labeling dated ,d+[DATE] documented items with printed expiration dates should still be dated upon opening and discarded by the expiration date on the item. Any food items brought in by staff members for themselves must be dated and labeled with their names. Any drink items sent up by the kitchen should also be dates. Any bottled drink items (juices) were to be dated when opened and placed in the refrigerator. These juices were good for 72 hours after opening. The policy and procedure documented the dietary department would clean and inspect labeled food items in all unit refrigerators and any outdated items would immediately be discarded.</p> <p>1a. During an observation of the Unit 2 Kitchenette on [DATE] at 10:00 AM revealed the following items were in the refrigerator:</p> <ul style="list-style-type: none"> -Approximately three cups of soup in a glass jar, undated, labeled with a name only. -An unopened ten-ounce container of humus, not labeled with a name, with the manufacturer stamp, Sell by [DATE]. -An individual poured cup of juice with lid, undated. -An opened ten-ounce container of Hot Chicken Dip, not labeled with a name, with the manufacturer stamp, Best by [DATE]. <p>This refrigerator had a sign attached to the front that read, Attention Night Shift - Please check/ clean refrigerator nightly. Everything that is opened must be dated/ labeled. If > (greater than) 3 days, must be thrown away!!! If not dated/ labeled, throw away. Please initial flow sheet nightly. This can be done by Nurse or CNA (Certified Nurse Aide).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Orchard Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Bates Road Medina, NY 14103	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview at the time of the observation, Licensed Practical Nurse Unit Manager #6 stated the nurse on duty each night was supposed to check foods in the refrigerator. All foods in the refrigerator should be labeled with a resident name and date, and individual juices should be labeled with the date they were poured. Licensed Practical Nurse Unit Manager #6 opened the container of Hot Chicken Dip, and there was a layer of water on the top and stated it should be thrown out. They also stated the individual cup of juice, and the container of humus should be thrown out.</p> <p>1b. During and observation of the Unit 1 Clean Utility Room on [DATE] at 10:25 AM revealed the following items were in the refrigerator:</p> <ul style="list-style-type: none"> -Four individual poured cups of pudding, undated. -An unopened eight-ounce container of milk with the manufacturer stamp, Best by 30 [DATE]. -An unopened quart of two percent milk with the manufacturer stamp, Best Used by [DATE]. -Two opened 48-ounce containers of prune juice, not labeled with the date opened. -One facility pitcher of approximately four cups of orange juice, not labeled with the date poured. -One facility pitcher of approximately two cups of thickened orange juice, with a piece of tape on the lid that said, ,d+[DATE] Honey. -Two facility pitchers of approximately three cups each of a thickened clear beverage, not labeled with the date poured. <p>The refrigerator had a sign attached to the front that read, Attention Night Shift - Please check/ clean refrigerator nightly. Everything that is opened must be dated/ labeled. If > (greater than) 3 days, must be thrown away!!! If not dated/ labeled, throw away. Please initial flow sheet nightly. This can be done by Nurse or CNA (Certified Nurse Aide).</p> <p>During an interview at the time of the observation, Licensed Practical Nurse Unit Manager #3 stated the nurses and aides checked the refrigerator each night. They also stated foods should be thrown out on the manufacturer's best by date. Licensed Practical Nurse Unit Manager #3 stated they were certain that the poured cups of pudding were placed in this refrigerator yesterday, but they should have been labeled with the date they were made. They stated juices should be labeled with the date they were opened, and they were not sure why one pitcher of juice had a label that said, ,d+[DATE] Honey. They stated they were not sure when the juices were poured into the pitchers, so they would discard the juice.</p> <p>1c. During an observation of the Unit 3 Clean Utility Room on [DATE] at 11:30 AM revealed the following items were in the refrigerator:</p> <ul style="list-style-type: none"> -One unopened 5.3-ounce container of Greek yogurt, and was not labeled with a name, with the manufacturers stamp, [DATE]. -One individual paper cup of macaroni salad, undated, and was not labeled with a name. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One facility pitcher of approximately two cups of orange juice, and not was labeled with the date poured.</p> <p>-One facility pitcher of approximately two cups of cranberry juice and was not labeled with the date poured.</p> <p>-One facility pitcher of approximately two cups of a thickened clear beverage and was not labeled with the date poured.</p> <p>-One opened eight-ounce container of salad dressing, with the manufacturers stamp, Best When Used by 27 [DATE].</p> <p>The refrigerator had a sign attached to the front that read, Everything placed in the fridge must be labeled with a name and date.</p> <p>During an interview at the time of the observation, Licensed Practical Nurse Unit Manager #7 stated the nurse on midnights checked the refrigerator each night. They also stated the Greek yogurt probably belonged to a staff member and staff food did not belong in this refrigerator. They stated they were not sure who the macaroni salad belonged to and both items should be thrown out. Licensed Practical Nurse Unit Manager #7 stated the facility's policy was to throw out any item on the manufacturers best by or use by date, and the pitchers of juice should be dated when poured in the kitchen.</p> <p>1d. During a second observation of the refrigerator in the Unit 2 Kitchenette on [DATE] at 3:28 PM, the glass jar of soup that was originally observed on [DATE] remained, and at this time, the label contained the original name, plus ,d+[DATE] was written below the name.</p> <p>At this time, Licensed Practical Nurse #1 stated the night shift nurses were supposed to check this refrigerator. Licensed Practical Nurse #1 looked at the log on the front of the refrigerator and stated the initials of the person who checked this refrigerator on [DATE], according to the log, belonged to the night Nursing Supervisor. They stated the name on the glass jar of soup was a resident, they were not sure when the soup was brought in, and they were not sure who wrote ,d+[DATE] on the label.</p> <p>During an interview on [DATE] at 5:30 AM, Registered Nurse #1 stated that they were the 10:00 PM to 6:00 AM building supervisor, at minimum, one night a week. Registered Nurse #1 stated that they have never been told that the nourishment refrigerators need to be checked for expired or unlabeled food items on the 10:00 PM to 6:00 AM shift. Registered Nurse #1 added facility staff were to keep their personal food items in the break room refrigerator.</p> <p>During an interview on [DATE] at 5:40 AM, Certified Nurse Aide #4 stated they worked the 10:00 PM to 6:00 AM shift on Unit 3 and they were never instructed that they were to check the refrigerator for unlabeled or expired food items.</p> <p>1e. During an observation of the Unit 2 nourishment room on [DATE] at 5:40 AM revealed the refrigerator had 12 peanut butter and jelly sandwiches each dated [DATE] wrapped individually in plastic.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and observation on [DATE] at 5:54 AM, Certified Nurse Aide #1 stated there were 12 peanut butter and jelly sandwiches in the refrigerator and the date on the label was [DATE]. They stated the sandwiches should of have been thrown out. Additionally, Certified Nurse Aide #1 stated it was the nurses' responsibility to check the refrigerators.</p> <p>During an interview on [DATE] at 6:12 AM, Certified Nurse Aide #2 stated the residents' sandwiches in the refrigerator should have been thrown out after the third day. Certified Nurse Aide #2 stated residents could get sick from expired foods left in the refrigerator.</p> <p>During an interview on [DATE] at 1:15 PM, Food Service Director #1 stated nurses took care of the nourishment refrigerators on the resident units. This task used to belong to dietary staff and was changed to nursing staff a few years ago. They stated the general rule for food safety was to keep foods for three days after preparation or opening, and this would include sandwiches made in the kitchen and juices poured in the kitchen. Food Service Director #1 stated foods that were beyond the manufacturer's best by date should be thrown out, even if unopened because residents could get sick if they ate foods that were out of date. They also stated if nursing staff saw food in the nourishment refrigerators that was past three days from the date on the label or beyond the manufacturers best by date, they should throw the item out, or ask them about it if they were unsure.</p> <p>During an interview on [DATE] at 10:36 AM, the Administrator stated that cleaning out the unit refrigerators was a shared responsibility between nursing and dietary staff and that they should update the policy and procedure titled Proper Food and Drink Storage and Labeling to reflect this.</p> <p>2. During an observation of the main kitchen on [DATE] at 9:21 AM the oven door and was greasy on the inside and outside, the splatter guard behind the stove was heavily soiled with dried on black/brown debris, and the commercial coffee maker and the carafes were heavily stained. There was a desk top fan on the floor under the tray line that was dusty and rusty.</p> <p>During an interview on [DATE] at 9:50 AM, Food Service Director #1 stated that cleaning the kitchen was a shared responsibility by all kitchen staff and there was a cleaning duties assignment sheet posted that assigned certain areas and equipment to be deep cleaned on specific days. Food Service Director #1 also stated that equipment should be cleaned and wiped daily, as well.</p> <p>3a. During an observation on [DATE] at 11:56 AM in the main dining room servery, Cook #1 took their gloved hand, scraped the plated chicken and biscuits off a red inner lip plate, put the chicken and biscuits on a regular plate and set it aside on the servery. Cook #1 then wiped their glove on their pants, did not change their gloves, and continued to serve the meal with the same gloved hand. Cook #1 was also observed to place a biscuit on each plate with the same gloved hand through the entire meal service after touching multiple surfaces.</p> <p>During an interview on [DATE] at 12:16 PM, Food Service Director #1 stated they observed Cook #1 transfer food to a different plate and the plated food sat on the counter for a while. Food Service Director #1 also stated Cook #1 tried to serve the food that sat on the counter to a resident. Cook #1 should not be touching the food with their gloved hand and should have changed their gloves and used utensils to plate the biscuits and not their gloved hand.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:54 PM Cook #1 stated they thought it was ok to use their gloved hand to pick up the biscuits and to be honest they thought it was ok to remove the food from the red inner lip plate and transfer it to a regular plate and serve it to a resident. They did not feel they had to change their gloves.</p> <p>During an interview on [DATE] at 2:16 PM, Infection Preventionist #1 stated food should be served with utensils and not using their hand. Their gloves should have been changed and that was an infection control issue.</p> <p>415.14 (h)</p> <p>SubPart ,d+[DATE] Food Service Establishments</p> <p>,d+[DATE].31(a), ,d+[DATE].43(e), ,d+[DATE].110(d), ,d+[DATE].71</p>		

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<p>F 0848</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>43785</p> <p>Based on interview and record review conducted during the Standard survey completed on 4/16/24 the facility did not ensure the Binding Arbitration Agreement provides for the selection of a neutral arbitrator agreed upon by both parties and the agreement provides for the selection of a venue that is convenient to both parties. Specifically, three (Resident #85,137,192) of three residents reviewed there was no documented evidence the arbitration agreement addressed the selection of a neutral arbitrator agreed upon by both parties and the selection of a venue that is convenient to both parties.</p> <p>The finding is:</p> <p>The policy and procedure titled Entering into Binding Arbitration Agreements dated 10/24/22, documented a pre-dispute arbitration agreement is a binding agreement to resolve a future unknown dispute with an arbitrator prior to any issue or dispute arising. The policy did not address the use of a neutral arbitrator agreed upon by both parties and selection of a venue convenient to both parties.</p> <p>The facility's Arbitration Agreement documented that both parties agreed that any disputes will be resolved by binding arbitration administered by the American Arbitrators Association. If the American Arbitrators Association does not enforce pre-dispute arbitration agreements, then any other reasonably comparable arbitration association chosen solely by the facility shall be an acceptable replacement. The Arbitration Agreement did not address the use of a venue convenient to both parties.</p> <p>Review of the Arbitration Agreement for Resident #85 dated 4/3/24, Resident #137 dated 3/19/24, and Resident #192 dated 4/2/24, revealed there was no documented evidence the agreement addressed the selection of a neutral Arbitrator agreed upon by both parties and the selection of a venue that was convenient to both parties.</p> <p>During an interview on 4/12/24 at 10:03 AM, the Admission Coordinator stated there wasn't language in the Arbitration Agreement to include choosing a neutral arbitrator and an agreed upon location. The Admission Coordinator stated they weren't aware of the requirements and the form was what their corporate office provided. The Admission Coordinator stated it seemed to say the facility would choose the arbitrator.</p> <p>During an interview on 4/16/24 at 8:29 AM, the Administrator stated the Arbitration Agreement used by the facility was a corporate form. The Administrator stated the agreement didn't include the language of selecting a neutral arbitrator and didn't know if the American Arbitrators Association was considered a neutral arbitrator. The Administrator stated their Arbitration Agreements should follow the regulations for protection of the residents. The Administrator stated there had not been any disputes that have been settled through the arbitration process.</p> <p>10 NYCRR 415.30</p>		