

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Lewis County General Hospital-Nursing Home Unit		STREET ADDRESS, CITY, STATE, ZIP CODE 7785 North State Street Lowville, NY 13367	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>37516</p> <p>Based on observation, record review, and interview during the recertification survey conducted 7/24/2024-7/30/2024, the facility did not ensure a resident's ability to safely self-administer medications was clinically appropriate for 1 of 1 resident (Resident #85) reviewed. Specifically, Resident #85 had 6 medications left in a medication cup in their room and there was no documented evidence the resident was assessed to determine their ability to safely self-administer medications or had a physician order for self-administration of medications.</p> <p>Findings include:</p> <p>The undated facility policy, Self-Administration of Medications, documented if a resident wished to self-administer medications the interdisciplinary team would assess the resident's cognitive, physical, and visual abilities to administer his/her own medications.</p> <p>Resident #85 had diagnoses including dementia. The 4/30/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required set-up or clean-up assistance for eating and oral hygiene, and was dependent to substantial/maximal assistance for all other activities of daily living.</p> <p>The 5/21/2024 quarterly comprehensive care plan meeting note by Social Worker #6 did not document if the resident was able to self-administer medications.</p> <p>Physician orders for routine medications as of 7/25/2024 documented:</p> <ul style="list-style-type: none"> <li>- amlodipine besylate (treats high blood pressure) 10 milligrams by mouth daily (order date 11/29/2022).</li> <li>- aspirin enteric coated 81 milligrams by mouth daily (order date 11/29/2022).</li> <li>- losartan potassium (treats high blood pressure) 50 milligrams by mouth twice daily (order date 11/28/2022).</li> <li>- budesonide/formoterol fumarate (treats lung disease) 2 puffs twice daily (order date 11/28/2022).</li> <li>- furosemide (diuretic) 40 milligrams daily (order date 12/6/2022).</li> </ul> <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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- umeclidinium bromide (treats lung disease) 62.5 micrograms inhale daily (order date 7/20/2023).</li> <li>- atorvastatin calcium (treats high cholesterol) 40 milligrams by mouth every 48 hours (order date 2/13/2024).</li> <li>- famotidine (treats excess stomach acid) 20 milligrams by mouth daily (order date 3/20/2024).</li> <li>- glipizide (treats diabetes) 5 milligrams by mouth daily (order date 7/13/2024).</li> <li>- insulin human lispro (rapid acting insulin) subcutaneous injection before meals and at bedtime/sliding scale (order date 7/1/22024).</li> <li>- insulin glargine (long-acting insulin) 5 units subcutaneous injection twice daily (order date 7/12/2024).</li> <li>- alendronate sodium (treats osteoporosis) 70 micrograms by mouth every 7 days (order date 7/25/2024).</li> </ul> <p>There was no physician's order for the resident to self-administer medications.</p> <p>The July 2024 Medication Administration Record documented the following medications were administered to the resident on 7/25/2024 during the morning (day shift) medication pass by Licensed Practical Nurse #9:</p> <ul style="list-style-type: none"> <li>- amlodipine besylate 10 milligrams at 9:12 AM.</li> <li>- aspirin enteric coated 81 milligrams at 9:18 AM.</li> <li>- losartan potassium 50 milligrams at 9:17 AM.</li> <li>- furosemide 40 milligrams at 9:18 AM.</li> <li>- famotidine 20 milligrams at 9:18 AM.</li> <li>- glipizide 5 milligrams at 9:18 AM.</li> </ul> <p>There was no self-administration of medications assessment in the resident's medical record.</p> <p>During an observation on 7/25/2024 at 9:22 AM, the resident had a medication cup on their overbed tray table in their room. The cup contained 6 various sized white pills. The medication nurse, Licensed Practical Nurse #9, was in another resident room. At 9:49 AM Resident #85 stated they had taken their pills. The empty medication cup was observed in the trash can. During the continuous observation from 9:22 AM to 9:49 AM, Licensed Practical Nurse #9 never re-entered the resident's room to verify they had taken their medications.</p> <p>During an interview on 7/26/2024 at 9:35 AM, Resident #85 stated the nurses sometimes left pills on their overbed table without watching them take the pills.</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 - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48052</p> <p>Based on observation, record review, and interview during the recertification and abbreviated (NY00308041 and NY00343021) surveys conducted 7/24/2024-7/31/2024 the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for 2 of 4 resident units (Units 1 and 3) observed and for 1 of 4 residents (Resident #77) reviewed.</p> <p>Specifically:</p> <ul style="list-style-type: none"> <li>- Unit 1 (dementia unit, also known as the Rainbow Community) had environmental accident hazards readily accessible to residents.</li> <li>- Resident #77, who resided on Unit 1, had a history of wandering throughout the unit and ingesting inedible items, including bar soap. Resident room [ROOM NUMBER] was observed with multiple bars of soap on the sink counter.</li> <li>- the door to the clean utility room on Unit 1 was unsecured and contained oxygen equipment, wound care supplies, and other nursing care items.</li> <li>- Unit 1 common area had metal wheelchair leg rests on a table.</li> <li>- An unsecured, open cart with needle-nose pliers and other electrical test items was left unattended in the hallway.</li> <li>- Unit 2 had environmental accident hazards in resident rooms including a four-slice toaster and a microwave on a long dresser at the foot of a bed, and a microwave on the dresser behind the head of a bed.</li> </ul> <p>Findings include:</p> <p>The facility philosophy for the Rainbow Community (Unit 1) dated 3/2006, documented every resident at the facility had the right to thrive, to flourish, and to be treated with dignity and function at the highest practicable level. The environment and creative caring concern for residents resulted in special approaches to individuals with the diagnosis of dementia.</p> <p>The facility policy, Behavior Management, revised 6/2024, documented the facility promoted and supported a resident-centered approach to care. Behavioral health encompassed a resident's whole emotional and mental well-being. Training would be completed for all frontline staff on the care and services of residents with behavioral health needs and dementia which included caring for the residents' environment and care of the cognitively impaired residents.</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 - Some</p>	<p>The facility policy, Food preparation on all Units and in Facility Departments, reviewed by the facility 3/2024, documented staff were to follow manufacturer's instructions for items being prepared in a microwave or toaster and were not to leave the microwave or toaster unattended until the cycle was complete. The policy did not include use of toasters or microwaves in resident rooms.</p> <p>The facility policy, Electrical Equipment, effective 7/2023, documented any new electrical equipment brought in by a resident's family had to be inspected and tagged by the Plant Operations Department before it could be used. It was the responsibility of the residential health care facility staff to enter a Plant Operations work order requesting the inspection of the equipment.</p> <p>Resident #77:</p> <p>Resident #77 had diagnoses including dementia with behavioral disturbance, major depressive disorder, and insomnia. The 6/3/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had inattention and disorganized thinking that was continuously present, did not wander, did not exhibit behavioral symptoms, and was independent for bed transfers and ambulation.</p> <p>A facility incident dated 12/1/2023 at 6:30 PM and entered by documented Resident #77 wandered into other resident rooms and throughout the unit while awake as the resident was independent. The resident had been witnessed with a soapy smell coming from their mouth and white residue around their mouth. The resident was observed on video coming out of resident room [ROOM NUMBER] with the soap bar. To prevent reoccurrence, the staff would ensure residents' personal hygiene products were locked up if residents did not independently use them. For residents who preferred to have their soap in the bathroom, travel containers that closed would be ordered and they would ensure residents could use them. An addendum to the report was made on 1/19/2024 that documented the residents and staff had been using the travel soap containers.</p> <p>A facility incident report dated 3/19/2024 at 7:57 PM documented Resident #77 was found with a bar of soap in their mouth; there were no chunks of soap gone but the soap bar had bite marks in it. The resident had a reaction to the soap indicated by a swollen lip. An addendum added on 3/21/2024 by the Registered Nurse Unit Manager #17 documented residents had taken soap out of the soap containers and Resident #77 found them in the rooms. The soap used on the unit was changed to a different soap Resident #77 was not sensitive to.</p> <p>The 7/23/2024 Comprehensive Care Plan documented the resident was independent with ambulation, was not allowed condiment packages on their meal tray after setting up to prevent accidental consumption of non-food items, required frequent visual checks for behaviors, and had a history of wandering and invading the privacy of others. The care plan documented the resident did not have a soap preference. The resident stayed up late at night. Make environment safe for exploring. Eliminate items that could cause harm but offer substitutions.</p> <p>The following observations were made:</p> <p>- On 7/24/2024 at 11:52 AM Resident #77 was walking up to the activities cart and reached their hand into the basket that contained the nail polish. Activities Aide #30 told the resident they could paint their nails. Resident #77 walked away from the cart and went into resident room [ROOM NUMBER]'s bathroom.</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 - Some</p>	<p>- On 7/25/2024 at 9:43 AM Resident #77 was wandering to the unit entrance door pushing on the door. An unidentified certified nurse aide called the resident's name and the resident turned away from the door. They wandered back down the hallway with an Alzheimer's association pamphlet in their hand. At 2:21 PM Unit Helper #19 took the resident out of room [ROOM NUMBER] for a walk down the hallway to their own room.</p> <p>- On 7/26/2024 at 9:40 AM Resident #77 was walking into room [ROOM NUMBER]. At 10:05 AM, Resident #77 was lying asleep in the window side bed in resident room [ROOM NUMBER]. At 12:51 PM, they took a baby doll from the nursing station and walked down the hallway.</p> <p>- On 7/29/2024 at 12:40 PM, Resident #77 was lying on a bed in resident room [ROOM NUMBER].</p> <p>- On 7/29/24 at 4:36 PM the bathroom sink in resident room [ROOM NUMBER] had 3 pieces of disintegrating white soap: one in the sink, one in between the cold water handle and faucet, and one in between the hot water handle and faucet.</p> <p>- On 7/30/24 at 10:17 AM the bathroom sink in resident room [ROOM NUMBER] had 2 pieces of disintegrating white soap: one in between the cold faucet handle and faucet, and one between the hot water handle and faucet.</p> <p>- On 7/30/2024 at 10:27 AM, Resident #77 was wandering into room [ROOM NUMBER]'s bathroom.</p> <p>During an interview on 7/25/24 at 10:03 AM, Resident #77's family representative stated they had been informed over the last few months the resident had attempted to ingest two bars of soap and a foam Easter egg. The staff could not tell them where the resident had obtained the soap bars or the foam Easter egg. They had informed the social worker that the interventions that were put into place after the first incident with the soap were not working and they needed to take away the resident's access to soap. They felt lack of supervision was an issue on the unit.</p> <p>Accident Hazards on Units 1 and 3:</p> <p>Unit 1 (dementia unit) observations:</p> <p>- On 7/24/2024 at 10:48 AM a gray handled, open bag full of wound care supplies which included dressings in wrappings, adhesive bandages, saline syringes, and scissors were on the lower counter of the nursing station within reach of a resident.</p> <p>- On 7/24/24 at 11:40 AM the bathroom of resident room [ROOM NUMBER] had therapeutic shampoo with ingredients consisting of coal tar 0.5%, sitting on the sink with a prescription label for a resident.</p> <p>- On 7/24/24 at 11:43 AM the bathroom of resident room [ROOM NUMBER] had two full bags of shampoo and body wash on the floor for a dispenser under the sink and a bar of soap on the floor of the shower.</p> <p>- On 7/24/24 at 11:49 AM the window side of resident room [ROOM NUMBER] had a 250 milliliter bottle of wound solution on the nightstand. The pharmacy label on the bottle had a dispense date documented as 7/12/2024.</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 - Some</p>	<ul style="list-style-type: none"> <li>- On 7/25/2024 at 2:38 PM a contract employee was in a closed clean linen room and left their open cart unattended in the hallway. The cart contained tools, electrical testers, needle-nose pliers, electrical tape, a laptop, stickers, and small packets of wipes. At 2:41 PM, the contract employee returned to the cart, walked away, and left the cart unattended in the hallway.</li> <li>- On 7/25/24 at 2:02 PM the bathroom of resident room [ROOM NUMBER] had two dispenser bags of shampoo and body wash hanging over the edge of the sink, a bar of soap was on floor of the shower, and the therapeutic shampoo with coal tar 0.5% was on top of the paper towel dispenser.</li> <li>- On 7/25/24 at 2:03 PM the window side of resident room [ROOM NUMBER] had a medicine cup with ointment on the bedside table and a bottle of wound wash on the nightstand.</li> <li>- On 7/26/24 at 9:58 AM in resident room [ROOM NUMBER] there was a bag of shampoo and soap on the bedside table next to the bathroom door. The therapeutic shampoo with coal tar 0.5% was on the towel dispenser in the bathroom.</li> <li>- On 7/29/24 at 10:06 AM there were metal wheelchair legs on a table in the back corner of the unit outside resident room [ROOM NUMBER].</li> <li>- On 7/29/24 at 11:00 AM the door to the clean linen room across from resident room [ROOM NUMBER] was partially open. The room contained oxygen cylinders and medical supplies such as bandages, tape, and disposable bed pans. There were no staff in the clean linen room at that time.</li> <li>- On 7/29/24 at 4:36 PM the bathroom sink in resident room [ROOM NUMBER] had 3 pieces of disintegrating white soap: one in the sink, one in between the cold water handle and faucet, and one in between the hot water handle and faucet.</li> <li>- On 7/30/24 at 10:17 AM the bathroom sink in resident room [ROOM NUMBER] had 2 pieces of disintegrating white soap: one in between the cold faucet handle and faucet, and one between the hot water handle and faucet.</li> <li>- On 7/30/24 at 10:14 AM resident room [ROOM NUMBER] had a bag of soap and shampoo for the dispenser on the sink in the bathroom.</li> </ul> <p>Unit 3 observations:</p> <ul style="list-style-type: none"> <li>- On 7/24/24 at 12:15 PM resident room [ROOM NUMBER] had a toaster and a microwave.</li> <li>- On 7/24/24 at 12:37 PM resident room [ROOM NUMBER] had a microwave with a 2024 black sticker on the appliance.</li> <li>- On 7/26/24 at 12:14 PM resident room [ROOM NUMBER] had a microwave on their dresser behind the bed. The microwave had a 2024 black circular sticker on it,</li> <li>- On 7/26/24 at 12:16 PM resident room [ROOM NUMBER] had a long dresser at the foot of the bed that had a four-slice toaster and a small microwave; both items had a circle sticker with 2024 on it.</li> </ul> <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 - Some</p>	<p>During an interview on 7/29/2024 at 4:58 PM, the Director of Nursing stated the procedure for residents who brought in their own items was the unit clerk would put in a work order for the maintenance department, and a maintenance employee would go to the floor and inspect the equipment before use. Staff would document what the maintenance staff was to inspect in the work orders and Maintenance would document what was inspected. They did have some residents who were allowed to have a microwave, but they did not have a toaster policy. They were not aware the resident in room [ROOM NUMBER] had a toaster.</p> <p>During an interview on 7/29/2024 at 5:02 PM, Registered Nurse Manager #28 stated the risk of having a toaster and microwave in a resident room could be the potential for something catching on fire and burning. There were some wandering residents on the unit, but they were unsure if they would wander into room [ROOM NUMBER]. They followed the directions on a package of food when heating up an item but did not take the temperature of the food, so there was always a risk of burns. Residents were not care planned to use a toaster or a microwave in their room, but they did have care plans for residents who preferred their coffee hotter. There should be a care plan to say if they could use the equipment properly.</p> <p>During an interview on 7/29/2024 at 5:07 PM, the Director of Plant Operations stated they did not have a master list of equipment/appliances residents could have in their rooms. A work order would document what the equipment/appliance was. They were unaware the resident in room [ROOM NUMBER] had a toaster. A toaster could pose a safety risk for fires, burns, and electrocution.</p> <p>During an interview on 7/30/24 at 10:19 AM, Unit Helper #21 stated residents were showered in the bathroom in their rooms. They did not believe medicated shampoos or soap bars were supposed to be left in the bathrooms, but it depended on what a resident's plan of care stated. Wheelchair leg rests were not supposed to be left out on the unit. There was a designated area to put wheelchair leg rests away as it was a safety hazard to leave them out. The clean utility room door should be pulled shut as that was where they stored their supplies and the clean laundry. They had several residents who wandered around the unit and in and out of other resident rooms. Resident #77 was one of those residents.</p> <p>During an interview on 7/30/24 at 10:30 AM, Licensed Practical Nurse #22 stated most of the residents on the unit wandered in and out of other resident rooms. The showers in resident rooms usually had a bin with soap in it that was locked up after the shower was completed. Soap bars were okay to be left in a resident's bathroom, but all liquid soaps should be locked up. They did not have travel containers for bar soaps on the unit and the bars of soap were just left out. The bags of shampoo and body wash for the dispensers should not be left on the floor. Medicated shampoo should not be left in a resident's room, it should be given back to the nurse or brought into the clean utility room. Wheelchair leg rests should not be left out on a table on the unit and were supposed to be put in a resident's closet, on the wheelchair, or a pocket on the back of the wheelchair when not in use. The clean utility room door should not be accessible to residents. They could get stuck in the room and panic if the door was to shut completely behind them.</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 - Some</p>	<p>During an interview on 7/30/24 at 10:48 AM, Certified Nurse Aide #23 stated they had several residents who wandered in and out of other resident rooms and removed items. If a resident was showered in their room, medicated shampoos should go back to the nurse to be locked up in the medication room. Non-medicated shampoos should be locked up in a resident's closet or in the cabinet in the resident's bathroom. Bars of soap were not to be left out and could be stored in the mirrored cabinet. Soap that was left out could be a hazard as a resident could eat it. The soap bags that went into the dispensers should be thrown out when empty and placed in the dispensers when full. Wheelchair leg rests should not be left out as a resident could pick them up or trip over them. The clean utility room door should be pulled shut and locked.</p> <p>During an interview on 7/30/24 at 11:32 AM, the Director of Nursing stated they were aware that Resident #77 had two incidents where they attempted to ingest a bar of soap. The soap was now non-toxic because of the incidents. Some residents had soap bars accessible in their rooms if they were able to use them independently; otherwise, they were locked in their closets in shower caddies. The bagged shampoo and soap for the dispensers should not be left on the sinks or the floors of resident bathrooms. Medicated shampoos and wound washes should not be left in resident rooms, as they could be a potential hazard on the dementia unit. Wheelchair leg rests should not be left out on the dementia unit. Residents could pick up the leg rests and they could be a potential hazard. A maintenance or bio-med employee leaving their cart on the dementia unit unattended was not appropriate, and leaving their cart on outside of a closed door was considered unattended.</p> <p>During an interview on 7/30/2024 at 11:54 AM, the Director of Plant Operations stated when maintenance went to the dementia unit, they were supposed to keep all their tools secured and not out on the unit. They should also take as little equipment as possible onto the unit. The bio-med staff member who was on the unit with the open cart was contracted with the hospital. Contracted employees went through the same trainings as the facility staff.</p> <p>During an interview on 7/30/2024 at 12:03 PM, Bio-Med Technician #25 stated they were on the dementia unit recently. They had not received any training regarding dementia residents or the dementia unit specifically, only safe patient handling. Their open cart should not had been left unattended while on the dementia unit. Going behind a closed clean utility door with their cart outside the room in the hallway was considered unattended. An unattended cart could have been taken by a resident and items including needle nose pliers and other equipment, could be considered a safety hazard if left unattended on the dementia unit.</p> <p>10 NYCRR 483.25(d)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2024
NAME OF PROVIDER OR SUPPLIER  Lewis County General Hospital-Nursing Home Unit		STREET ADDRESS, CITY, STATE, ZIP CODE  7785 North State Street Lowville, NY 13367	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>27522</p> <p>48675</p> <p>Based on observation and interview during the recertification survey conducted 7/24/2024-7/30/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 meal test tray reviewed (the 7/26/2024 lunch meal on Unit 3 and the 7/29/2024 lunch meal on Unit 2). Specifically, food was not served at palatable and appetizing temperatures during the lunch meals on 7/26/2024 and 7/29/2024. Additionally, Resident #26 stated the food did not taste good.</p> <p>Findings include:</p> <p>The facility policy Food Temperatures effective date 12/2019 documented:</p> <ul style="list-style-type: none"> <li>- Temperatures of all food items would be taken and properly recorded prior to service of each meal and ensure quality and safety of food/drinks.</li> <li>- All hot food items must be held and served at a temperature of at least 140 degrees Fahrenheit.</li> <li>- All cold items must be stored and served at a temperature of 41 degrees Fahrenheit or below.</li> </ul> <p>During an interview on 7/24/2024 at 12:37 PM, Resident #26 stated they were served cold food, and it did not taste good.</p> <p>During a lunch meal observation on 7/26/2024 at 1:01 PM on Unit 3, Resident #26 was served their lunch meal tray. A replacement tray was ordered, and Resident #26's original meal tray was tested . The roast beef was measured at 128 degrees Fahrenheit, the green beans were 118 degrees Fahrenheit, the orange juice was 54.3 degrees Fahrenheit, the butterscotch pudding was 51.8 degrees Fahrenheit, and the vanilla pudding was 46.6 degrees Fahrenheit.</p> <p>During an interview on 7/26/2024 at 1:02 PM, Licensed Practical Nurse #20 stated cold items were sent to the unit on a cart from the kitchen, and hot items were served from the steam tables on the unit. They were unsure what temperatures hot and cold food items should be when served.</p> <p>During a lunch meal observation on 7/29/2024 at 12:51 PM on Unit 2, a sample lunch meal tray was requested. At 12:54 PM, the lunch meal tray was served and tested . The lasagna was measured at 123 degrees Fahrenheit, the broccoli was 105 degrees Fahrenheit, the mashed potatoes were 135 degrees Fahrenheit, the gravy was 120 degrees Fahrenheit, and the soup was 123 degrees Fahrenheit.</p> <p>During an interview on 7/29/2024 at 1:05 PM, the Food Service Director stated all hot food items should be served at 140 degrees Fahrenheit or higher and cold food items should be served between 35 degrees Fahrenheit and 40 degrees Fahrenheit. The lasagna, broccoli, gravy, and soup were not acceptable temperatures. Hot food was served directly from the steam table and the food should hold temperatures. It was important for residents' food to be served at palatable and safe temperatures.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/30/2024 at 10:40 AM, the Food Service Director stated they were responsible for completing test trays, they did not have a set schedule, and they were completed randomly. They looked at a meal's appearance, taste, and temperature, and ensured the food on the tray matched the ticket. The staff were not made aware prior to the completion of a test tray, and they would complete them more often if they noticed any negative trends. The orange juice, roast beef, and green beans were not acceptable temperatures, and the pudding should have been served cold. Hot food items should be served at a minimum of 140 degrees Fahrenheit and cold food items should be served below 40 degrees Fahrenheit.</p> <p>10NYCRR 415.14(d)(1)(2)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>48052</p> <p>Based on observation, interview, and record review during the recertification survey conducted 7/24/2024-7/30/2024, the facility did not ensure residents were provided appropriate assistive devices and appropriate assistance to maintain or improve their ability to eat and or drink independently for 1 of 1 resident (Resident #29) reviewed. Specifically, Resident #29 was not served food or drinks at meals as planned.</p> <p>Findings include:</p> <p>The facility policy, Meal Delivery, revised 1/2024, documented dietary staff would load meal trays in the kitchen with the appropriate meal service items according to the meal ticket before each meal. This would include adaptive equipment. Meal tickets would be carefully reviewed when passing meal trays to ensure the correct resident was served, all adaptive equipment was present, and tray notes were reviewed. If staff believed something on the meal ticket or the meal itself was incorrect, the meal should not be served, and the Dietary Department contacted for a replacement meal.</p> <p>Resident #29 was admitted to the facility with diagnoses including dementia with behaviors, history of a stroke, and catatonic disorder (neuropsychiatric disorder that can cause abnormal movements). The 5/13/2024 Minimum Data Set assessment documented the resident had moderate cognitive impairment, required supervision or touching assistance with eating, and had a mechanically altered diet.</p> <p>The 10/13/2023 Occupational Therapist #31 evaluation documented Resident #29 had increased tremors with feeding and required maximal assistance. The prior level of functioning was supervision to touch assistance with eating, cups half-full, food in bowls, unbreakable meal service items, one item at a time with no tray, soup spoons, and remove empty items as finished with them. Staff needed reeducation regarding the resident's care plan for one item at a time and cups half full. No changes to care plan were needed.</p> <p>The 5/15/2024 quarterly dietary assessment documented the resident had an easy to chew regular diet with thin liquids. Their weights were stable, and the resident had adequate meal intakes. The resident was to receive supervision, touching assistance with partial or moderate assistance for meals. The assessment did not document adaptive equipment.</p> <p>The 5/30/2024 updated comprehensive care plan documented the resident needed assistance with eating. Interventions included supervision or touch assistance, fill cups only half-full, food in bowls, soup in mugs, plastic dishes due to resident having a history of throwing them, one item at a time, do not give a tray, remove each dish immediately after the resident finished one, and provide a soup spoon instead of regular spoon. The resident should sit in a regular chair with their feet on the floor in the dining room. Encourage the resident to eat in the dining room but may eat at desk if overstimulated.</p> <p>The 7/25/2024-7/30/2024 Resident #29's meal tickets documented supervision at meals, fill cup half-full, no knife, use unbreakable dishes, one item at a time, food served in bowls, soup in a mug, use a soup spoon instead of regular spoon, and do not use glass dishes.</p> <p>(continued on next page)</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/2024 meal consumption records documented the resident required set-up to maximal assistance for eating and the resident ate 50-100% most meals.</p> <p>Resident #29 was observed at the following times:</p> <ul style="list-style-type: none"> <li>- on 7/24/2024 at 12:46 PM, the resident was brought into the dining room for lunch. Their meal ticket documented food in bowls (was circled), soup in mug, soup spoon, no glass dishes, regular easy to chew food texture, thin liquids, fill cup half-full, no knife, unbreakable dishes, items one at a time, and supervise. The resident received a ground hot dog on a bun and a peeled banana served on a regular plate. Three cups were placed on the table within the resident's reach. One cup was 3/4 full of iced tea and one cup was filled almost to the brim with chocolate milk.</li> <li>- on 7/24/2024 at 1:05 PM, Registered Nurse #29 came to the table where the resident was seated, stood next to them, and moved the drinks, bowl of beans, and macaroni salad closer to the resident. The nurse gave the resident a spoon, the resident took a bite of food, and the nurse left the dining room. The nurse returned to the dining room a minute later and wiped up a mess the resident made on the table. The nurse put the beans and macaroni salad on the resident's plate and stood next to the resident while the resident was eating. The nurse redirected the resident at times.</li> <li>- on 7/26/2024 at 12:53 PM, Activities Director #30 brought the resident into the dining room where their lunch was sitting at the table. The resident was served a cup of chocolate milk that was filled almost to the brim.</li> <li>At 1::08 PM, Licensed Practical Nurse #22 served the resident a sandwich and cheese doodles on a regular plate.</li> <li>- on 7/29/2024 at 12:46 PM the resident was served a cup of chocolate milk filled to the brim with chocolate milk. The resident's meal was served in separate bowls and provided to the resident all at the same time.</li> </ul> <p>During an interview on 7/30/2024 at 10:30 AM, Licensed Practical Nurse #22 stated Resident #29 should not have been given all their bowls at once on the table. If Resident #29 received all their bowls at once on the table, they would become overwhelmed and play with their food instead of eating it. They stated Resident #29 should not be given full glasses when their meal ticket listed half-full because when they picked up the glass their hands shook, and the liquid spilled out of the cup.</p> <p>During an interview on 7/30/24 at 10:40 AM, Food Service Director #1 stated meal ticket directions were generated by the dietitians and therapy. Residents were evaluated and the dietitians updated residents' tickets based on the evaluation. The Director expected staff to prepare the meal per each resident's meal ticket instructions. Meal tickets were printed daily.</p> <p>During an interview on 7/30/2024 at 10:48 AM, Certified Nurse Aide #23 stated they were responsible to ensure the special instructions on meal tickets were followed. Resident #29's food should be served in bowls, glasses of liquids should be served half-full, and food should be given one item at a time in a bowl for every meal. These instructions were important because the resident threw their food and cups at times. They stated staff that floated to the unit did not always follow meal ticket instructions.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/30/2024 at 12:17 PM, Registered Dietitian #29 stated the special instructions on residents' meal tickets were provided by input from Nutrition, Occupational Therapy, and Speech-Language Pathology. It was the responsibility of the Dietary Department and Dietary Supervisors in the kitchen to update resident tickets as appropriate. They expected staff to follow the instructions that were on the ticket so the resident would have the best possible nutritional outcome, and to prevent any illnesses that might result from not eating well.</p> <p>10NYCRR 415.14(g)</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>27522</p> <p>40803</p> <p>Based on observation, record review, and interview during the recertification survey conducted 7/24/2024 - 7/30/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, 7 individual serving size portions of moist and minced fish were stored in cardboard containers dated 2/21 with ice buildup inside the containers; 1 cardboard box of cooked chicken was stored on top of 2 packages of flatbreads; the ice cream cooler contained an employee's personal 20-fluid ounce frozen bottle of water; and the tray line preparation cooler contained 10 sheet pans of uncovered coleslaw, and uncovered 4-ounce servings of strawberries with whipped topping.</p> <p>Findings include:</p> <p>The following observations in the main kitchen were made on 7/24/2024 between 10:30 AM and 11:01 AM:</p> <ul style="list-style-type: none"> <li>- In the walk-in freezer there were 7 individual serving size portions of minced and moist fish dated 2/21 with ice buildup on the inside of the containers, and there was 1 cardboard box of cooked chicken breast stored on top of 2 plastic sleeves of flatbread. The Food Service Director discarded the 7 portions of minced and moist fish and stated the cooked chicken should not be stored on top of the flatbread.</li> <li>- In the ice cream cooler there was an employee's personal 20-fluid ounce bottle of frozen water. The Food Service Director stated staff should not store personal food items with resident food items and discarded the frozen water bottle.</li> <li>- In the cold food prep cooler there were 10 sheet pans of uncovered coleslaw and uncovered 4-ounce servings of strawberries with whipped topping.</li> </ul> <p>During an interview on 7/30/2024 at 10:52 AM, the Food Service Director stated the moist and minced fish containers were discarded immediately. The chicken breast that was stored on top of the flatbread was cooked, but still could cross-contaminate the flatbread and pose a food safety issue. The frozen bottle of water was discarded immediately, and employees should not store personal food or drink items with resident food. It was important to maintain food safety in the main kitchen for the safety of the residents and staff.</p> <p>NYCRR10 415.14(h)</p>		