STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335451	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Hill Nursing and Rehabilitation Center	99 Golden Hill Drive Kingston, NY 12401

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 2) During an observation on 5/14/25 at 12:48 PM Resident #105, #93, #121 were served lunch and began eating. Fourth table mate, Resident #16 was not served lunch until 1:00 PM. Resident #93 verbalized that Resident #16 had not received lunch and repeatedly asked for them to be served. During an interview on 5/15/25 at 12:30 PM Certified Nurse Aide #17 stated they were not aware that all residents at the same table should have been served at the time before moving onto the next table. Unit Manager Registered Nurse #21 stated they were not aware of any residents' concern for everyone to be served at the same time. 10 NYCRR 415.3(d)(1)(i) Based on record review and interviews conducted during the recertification and abbreviated surveys (NY00376199), the facility did not ensure residents were treated in a dignified manor for 3 residents (Residents #1, #3, and #227), reviewed during a staff performance evaluation review, and for 1 resident (Resident #16) reviewed during dining. Specifically, 1) Review of Certified Nurse Aide #4's employment file revealed Residents #1, 3 and 227 were not treated in a dignified manner when requesting assistance from Certified Nurse Aide #4. 2) Resident #16 was served lunch 12 minutes later than the other residents at the table. Findings include: 1) A review of Certified Nurse Aide #4's employee file, during a Nurse Aide Performance Evaluation review on 5/14/25, revealed disciplinary notices for Certified Nurse Aide #4 related to customer service for Residents #1, #3, and #227. The 2/13/24 Occurrence Summary documented Resident #3 complained that they asked Certified Nurse Aide # 4 when they would be getting their hair washed. Certified Nurse Aide # 4's response made the resident feel like they were a bother and Certified Nurse Aide #4 did not want to help them. Certified Nurse Aide#4 was given a Corrective Discipline Notice and counseled on the importance of customer service being kind and respectful with all interactions with everyone, staff, resident, and family members. (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 - Some	The 2/13/24 Occurrence Summary documented Resident #227 complained Certified Nurse Aide #4 was in their room at bedtime, they were feeling weak but was assessed to be independent level of care. Instead of helping them, Certified Nurse Aide #4 stood in the room with an aggravated look telling the resident how to get themselves ready for bed. Resident #227 also reported that Certified Nurse Aide #4 seemed to not like their job and did not want to help when they come to answer the call bell. The conclusion documented Certified Nurse Aide #4 was given a Corrective Discipline Notice and was counseled on the importance of customer service being kind and respectful with all interactions with everyone, staff, residents, and family members. The 2/29/24 Occurrence Summary documented Resident #1's spouse complained that Resident #1 was completely soaked at lunch time, Certified Nurse Aide #4 came in their room and told the resident to stop ringing the bell so much. Certified Nurse Aide #4 got the resident out of bed and brought them in the bathroom. The resident sneezed on the certified nurse aide, so they left the room for some time and they had a bad attitude. The conclusion documented Certified Nurse Aide #4 was given a Corrective Discipline Notice. Certified Nurse Aide #4 was given the mission statement and spoken to at length regarding resident complaints about her body language and mannerisms and how they could affect residents and family members who were already upset about their loved one's health and wellbeing. During an interview on 5/19/25 at 11:07 AM, the Assistant Director of Nursing stated the complaints from families were related to the way Certified Nurse Aide #4 responded to a directive, which was either very curt or brass. The Assistant Director of Nursing stated they observed Certified Nurse Aide #4 while they provided care and stated they were good with the residents. When requested, the Assistant Director of Nursing was unable to provide documented evidence of the care observations with Certified Nurse Aide #4. They stated Resident #227 was removed from Certified Nurse Aide #4's assignment at the request of the resident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review and interviews during the recertification survey and abbreviated (NY00352562) surveys, the facility did not ensure that an investigation was completed for a resident with an injury of unknown origin for 1 (Resident #489) of 4 residents reviewed for abuse. Specifically, there was no documented evidence an investigation was conducted for Resident #489 with documented bruising on bilateral arms and left hip. The findings are: Resident #489 was admitted to the facility with diagnoses including cerebrovascular accident, non-Alzheimer's dementia, and muscle weakness. The 4/26/24 Minimum Data Set (assessment tool) documented the resident had severely impaired cognition and was dependent on staff with toileting hygiene, needed substantial assistance with shower/bathe self, partial assistance with personal hygiene and chair to bed transfer. The Comprehensive Care Plan, Resident is at Risk for Skin Impairment, last revised on 5/22/24, documented to observe skin redness, swelling or bruising with cares, provide comfort and well-fitting clothing, weekly skin observations, consult Physical and Occupational Therapy for proper positioning. The 1/19/2024 Physician's order documented Clopidogrel Bisulfate Tablet 75 MG (blood thinner), Give 1 tablet by mouth one time a day for blood clot. The 3/11/24 Physician's order documented Skin Check every day shift every Monday ensure skin check and shower is completed- fill out skin evaluation. The 6/24/24 Skin Observation Tool documented bruising on bilateral arms and small area remains on left hip. There was no documented evidence that an investigation was completed in relation to the resident's bruising on bilateral arms and the area on left hip. During an interview on 5/19/25 at 12:06 PM, the Acting Director of Nursing stated that there was no Accident/Incident Report for June 2024 for Resident #489. During an interview on 5/19/25 at 3:38 PM, Licensed Practical Nurse #16 stated that Resident #489 had very small skin discoloration spots on both arms and small area on their left hip, which did not look like bruises. They stated that they should not have documented those skin discoloration as bruises. Licensed Practical Nurse #16 stated when they found these skin discolorations, they did not have any concerns for abuse and decided not to document or report this to the manager. They stated that Resident #489 at times exhibited restlessness while sitting at the table and could banging their arms and legs against the table, and was on Clopidogrel (blood thinner). Licensed Practical Nurse #16 stated that they received annual in-services related to Accidents/Incidents and Abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 4:33 PM, Registered Nurse Supervisor #15 stated that when the Licensed Practical Nurse observed bruises of unknown origin, they should have reported that to the Registered Nurse Supervisor to initiate an investigation, which required to determine whether there was any abuse especially in cognitively impaired residents. The doctor and the resident's family needed to be informed. Registered Nurse Supervisor #15 stated that they had not heard anything from Licensed Practical Nurse #16 about Resident #489's bruises. During an interview on 5/20/25 at 10:51 AM, the Director of Nursing stated that once the nurse identified bruises of unknown origin, the nurse should have initiated an investigation, interviewed the staff and the resident, conducted a skin assessment, contacted the doctor and resident's family. In this case Licensed Practical Nurse #16 should have reported this to their supervisor to initiate an investigation, which was not done. 10 NYCRR 415.4(b)(1)(ii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 2) Resident #538 had diagnoses that included metabolic encephalopathy, hypertension, and muscle wasting. The 9/25/2024 admission Minimum Data Set (assessment tool) documented moderately impaired cognition, foley catheter, occasional incontinence of bowel, maximum assistance for toileting hygiene and transfers. The 12/18/2024 Discharge Minimum Data Set documented moderately impaired cognition, foley catheter, incontinent of bowel, dependent on assistance for toileting hygiene and transfers. The Certified Nurse Aide Kardex dated 12/7/24 documented Resident #528 required maximum assistance and was dependent on staff for all ADLs and transfers, except oral and personal hygiene. The September 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene and toilet transfers were completed on 9/24/24 day shift, 9/26/24 evening shift, and 9/21 and 9/25/24 night shift. The October 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene and toilet transfers were completed on 10/4/24 day shift and 10/31/24 evening and night shifts. The 10/22/24 and 10/29/24 nursing skin assessments documented dry fragile skin. The November 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene, and toilet transfers were completed on 11/6, 11/24, and 11/28/24 day shift and 11/30/24 night shift. The 11/5/24 nursing skin assessment documented dry fragile skin. The 11/12/24 and 11/20/24 nursing skin assessments documented bilateral groin reddened areas-anti fungal powder. The 11/21/24 wound consultation documented sacrum and left buttocks moisture associated skin damage. The 11/27/24 nursing skin assessments documented wound to buttocks-triad and dry protective dressing. The December 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene, and toilet transfers were completed on 12/10/24 day shift, 12/14/24 evening shift, and 12/1 and 12/5/24 night shift. The 12/4/24 and 12/11/24 nursing skin assessments documented wound to buttocks-triad and dry protective dressing. The 12/5/24 wound consultation documented sacrum and left buttocks moisture associated skin damage. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/20/25 at 10:07 AM, Registered Nurse Unit Manager #8 stated that Resident #538 required moderate-maximum assistance with washing and bathing, toileting hygiene personal hygiene and transfers. They expected Certified Nurse Aides to check and change Resident #538 every two-three hours. Peri care should be completed every shift regardless of whether a resident has foley catheter. There should not be omissions on the Documentation Survey Reports/Certified Nurse Aide's Accountability records. They stated if there was no documentation it was not done. 3) Resident #49 was admitted to the facility with diagnoses including non-Alzheimer's dementia, schizophrenia and muscle weakness. The Minimum Data Set (assessment tool) dated 2/15/25 documented the Resident #49 had severely impaired cognition and was dependent on staff assistance with toileting hygiene, required partial assistance with personal hygiene, and required supervision with chair to bed transfers. The Comprehensive Care Plan, Activities of Daily Living Needs, last updated on 8/14/23, documented Resident #49 required extensive assistance of one person with grooming/personal hygiene. During observations on 5/13/25 at 12:47 PM, on 5/14/25 at 11:01 AM, and on 5/15/25 at 1:32 PM Resident #49 was observed with long fingernails on both hands. During an interview on 5/15/25 at 1:39 PM, Certified Nurse Aide #17 stated they provided care today for Resident #49. They stated the resident was dependent on staff with assistance for personal hygiene, which included grooming task, such as shaving facial hair and trimming fingernails. The Certified Nurse Aide stated that they could see the resident's long fingernails on both hands, but did not have time to check the resident's fingernails today, and did not know when the resident's fingernails were last trimmed. During an interview on 5/15/25 at 2:01 PM, Licensed Practical Nurse #18 stated that they provide care for the resident at least three days a week. The nurse stated that when they started their shift and during the shift they observed Resident #49. Licensed Practical Nurse #18 observed Resident #49 and stated that the resident had long fingernails on both hands, which needed to be trimmed. The nurse stated that nobody reported to them about long fingernails and did not know when the resident's fingernails were last trimmed. They stated that since Resident #49 was not a diabetic, the Certified Nurse Aide was responsible for trimming the resident's fingernails. 10 NYCRR 415.12(a)(2) Based on observation, record review, and interviews conducted during the recertification and abbreviated surveys (NY00363395, NY00352562, NY00363234, NY00342723) from 5/13/25-5/20/25, the facility did not ensure each resident who was unable to carry out activities of daily living received the necessary care and services for 5 of 10 residents (Residents #49, #338, #538, #488, and #489) reviewed for Activities of Daily Living. Specifically, 1) for Residents #338, #538, #488, and #489, there was no documented evidence in the Certified Nurse Aide records Documentation Survey Report that assistance with activities of daily living was consistently provided, and 2) Resident #49 who required dependent assistance with activities of daily living was observed during multiple observations with fingernails that were long and ungroomed. The findings include: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The March 2024 facility policy, Activity of Daily Living, documented the facility will provide ADL care to all residents based on assessment of needs, which includes bathing, dressing, eating, transfers, toileting, bed mobility, ambulation. It documented it is the licensed nurse's responsibility to assess the resident to determine their ADL needs and the certified nurse aide's responsibility to provide care and assistance with care in accordance with the instructions (plan of care). 1. Resident #338 was admitted with diagnoses including Parkinson's disease, history of falls, and dementia. The 4/24/24 admission / Medicare-5 Day Minimum Data Set (resident assessment) documented Resident #338 had moderately impaired cognition, was frequently incontinent of bladder, and required moderate assistance with toileting hygiene, personal hygiene, and toilet transfers. The Certified Nurse Aide Kardex dated 5/15/2024 documented to provide moderate assistance with toilet transfers, toileting hygiene and personal hygiene. The April 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene and toilet transfers were completed on 4/20, 4/21 and 4/28/24 for day shift, 4/22, 4/24, 4/26, 4/27, and 4/28/24 for evening shift, and 4/19 and 4/30/24 for night shift. The May 2024 Documentation Survey Report contained no documented evidence that personal hygiene, toileting hygiene and toilet transfers were completed on 5/1, 5/4, and 5/5/24 for day shift 5/13/24 for evening shift, and 5/14 and 5/15/24 for night shift. During an interview on 5/16/25 at 9:38 AM, Licensed Practical Nurse #7 stated they did not know why there were blanks on some dates. They stated it could have been due to the cares not being completed or due to another reason. They stated the nurses were responsible to assure the certified nurse aides complete the resident's care and the unit manager was responsible to assure the Certified Nurse Aides complete documentation on the Documentation Survey Report. During an interview on 5/16/25 at 9:52 AM, Registered Nurse Unit Manager #8 stated the unsigned Documentation Survey Reports was due to Certified Nurse Aides not documenting the care they provided but they could not provide a reason for not documenting. During an interview on 5/16/25 at 11:09 AM, Certified Nurse Aide #9 stated the undocumented cares might have been incomplete because either the staff did not have time to document the cares, or the cares were not provided.

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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. Based on interview and record review during the recertification and abbreviated (NY00376199) survey from 05/13/25 through 05/20/25, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, five of five Certified Nurse Aides (#1, #2, #3, #4, #5) did not have a performance review documented at least once every 12 months. The findings include: Policy and Procedure Titled Staff Evaluations dated 1/25 documented the purpose is to establish a consistent and fair process for evaluating the performance of Nursing Home staff to ensure high-quality resident care, compliance with regulations and professional development. A review of 5 Certified Nurse Aide performance reviews noted 5 out of 5 Certified Nurse Aides had no annual performance appraisals in the last 12 months. Certified Nurse Aide #4, with a hire date of 10/24/23, had 14 corrective discipline notices dated 1/11/24 to 5/2/25 in their employment file. The notices included poor customer service, insubordination, failure to follow policy, absenteeism, tardiness, and violation of company policy. Certified Nurse Aide #4 was terminated on 5/2/25. The file did not contain an annual performance appraisal. Certified Nurse Aide #1 with a hire date of 9/5/23 had an undated and unsigned employee performance review in the Human Resource File. Certified Nurse Aide #2 with a hire date of 5/22/23, Certified Nurse Aide #3 with a hire date of 9/8/23, and Certified Nurse Aide #5 with a hire date of 11/28/21 had no performance appraisal in the last 12 month. During an interview on 05/20/25 at 11:56 AM, the Director of Human Resources stated the Unit Managers were responsible to complete Annual Performance Reviews. The Unit Managers should have reviewed the hire date and ensured the performance reviews were completed at least once every 12 months. The Unit Managers should have presented the evaluation to the employee and had them sign it. Once completed it should have been brought to Human Resources for filing. During an interview with the Unit Managers of C1 on 5/20/25 at 12:05 PM, they stated they were responsible to complete performance reviews. They had a list of staff members and the hire dates. Performance reviews should have been completed annually. During an interview on 05/20/25 at 12:36 PM, the Director of Nursing stated the with the Director of Nursing were responsible for completing annual performance reviews. They were unaware they were not being completed. 10NYCRR 415.26 (c) (2) (iii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview conducted during the recertification and abbreviated (NY00365130) surveys from 5/13/25 to 5/20/25, the facility did not ensure residents were provided food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, a test tray was sampled and found food was not served at a palatable, appetizing temperature; and many residents complained about the food. Findings include: The facility policy titled Meal Delivery documented, meals should be delivered promptly to ensure appropriate temperatures, and all staff is responsible to report any concerns regarding meal temperatures and resident satisfaction. During an interview on 05/13/25 at 10:52 AM, Resident #174 stated the food at the facility is terrible. The vegetables were often undercooked and hard, and the meats were often overdone. The meals came luke warm and alternates were offered but they were not very good either. During interviews on 05/13/25 at 3:27 PM and 05/16/25 at 10:52 AM, Resident #106 stated that they did not like the food at the facility. They stated the food quality was poor regardless of the mealtime and they refuse it. Stated they did not like most of the alternates offered either, so they just order out all the time. During an interview on 5/14/25 at 10:02 AM, Resident #202 stated they did not eat the food served, but ordered take out. During an interview on 5/15/25 at 11:31 AM, the Assistant Food Service Director stated there had been complaints about cold food. The facility had some enclosed insulated food carts that were used on the units further away from the kitchen. The units that were closer to the kitchen used the open racks for meal trays. The facility had a pellet system, and they had called the company to service the pellet system to make sure it was heating properly. During an interview on 5/15/25 at 1:23 PM, the Administrator stated there had been no recent complaints regarding cold food. Currently open racks are used to deliver food to closer units and closed carts were used for the further distance units. There was no timeline plan for moving over to the enclosed thermal carts for the entire building. On 5/16/25 at 11:17 AM, tray line food temperatures were taken with the Assistant Food Service Director. The fish was 140 degrees Fahrenheit, steak fries were 120 degrees Fahrenheit, the asparagus was 140 degrees Fahrenheit. The Assistant Food Service Director asked the cook to reheat the steak fries. On 5/16/25 at 11:49 AM lunch meal trays were delivered to unit C1 on an open rack. The lunch meal for Resident #174 was intercepted just prior to delivery to the room at 12:09 PM and was used as a test tray for palatability and temperature. The cod fish and asparagus taste were acceptable but temperature was lukewarm. The steak fries were cold with a tough texture. The soup taste was acceptable and had a temperature of 100 degrees Fahrenheit and the coffee was unappetizing and lukewarm at 78 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/25 at 1:33 PM with the Diet Clerk, they stated they visited Resident #202 almost every day for food preferences and offered items from all menus to try to achieve satisfaction. They stated Resident #202 complained about the food being served cold. During an interview on 5/19/25 at 2:28 PM Licensed Practical Nurse Charge Nurse #7, stated Resident #202 would go to the cafe if they did not like what was served at meals. During an interview on 5/19/25 at 3:55 PM, Resident #204's friend stated Resident #204 had reported to them that the meals were delivered cold day after day, and Resident #204 had expressed this to the staff with no resolution. 10NYCRR 415.14 (d)(1)(2)

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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 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. Based on observation and interviews conducted during the recertification survey from 5/13/25 to 5/20/25, the facility did not ensure food was distributed and served in accordance with professional standards for food service safety. Specifically, 1.) On initial kitchen tour, food items were found undated, unsealed, and expired. The handwash sink in food prep area did not work. 2) On follow-up kitchen tour, food temperatures were not at control level on the steam table and dietary staff did not wear proper hair/beard restraint or utilize hygienic practices. 3) The pantry refrigerator on Unit C1 contained undated foods, expired foods and an incomplete temperature log. Findings include: The facility policy Food Receiving and Storage, dated 1/30/24 included documentation that food shall be stored off the floor; all food items will be covered, labeled and dated; refrigerator and freezer temperatures must be monitored and logged; food must be dated and sealed/covered and held no longer than 72 hours. The facility policy Personal Hygiene dated 1/30/24 included documentation that employees must use hair restraint and beard restraint when applicable, refrain from touching face when preparing food, and properly wash hands. The Label and Dating Policy updated 2/4/16, and posted on the C1 Unit refrigerator, documented that all items in the refrigerator should be labeled properly with resident name, item description, and date opened. Every food item opened or freshly made has a 72-hour shelf life. All items will be discarded after that time. Anything without proper labeling will be discarded during floor stocking. 1) During the initial tour of the kitchen on 5/13/25 at 9:57 AM, the following items were observed: -In the freezer there were unsealed frozen hamburgers, unsealed chicken nuggets, and unsealed frozen rolls. There were waffles with an expiration date of 5/5/25. In the dry storage there were unsealed bag of granola and unsealed cranberry juice. The angel food cake mix had an expiration date of 2/2/24 and the biscuit mix expired 4/3/25. Boxes of grape jelly were observed stored on the floor. -In the refrigerator there was undated pepperoni, tortillas, humus, tossed salads, sandwiches, fruit cups and pudding. -The handwash sink was not working, and kitchen staff mentioned the sensor had not been working for about a week. During an interview with the Assistant Food Service Director at the time of the tour, they stated all food should be sealed once opened, all foods should be dated, and all staff was responsible for disposing of expired foods. They were unaware of sink sensor not working and would be notifying maintenance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335451	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Hill Nursing and Rehabilitation Center	99 Golden Hill Drive Kingston, NY 12401

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During a follow up visit to the kitchen on 5/16/25 at 11:17 AM, lunch food temperatures were taken with the Assistant Food Service Director for steam table service. The steak fries were 120 degrees Fahrenheit, and the puree meat was 130 degrees Fahrenheit. The Assistant Food Service Director advised staff to remove the items and replace with new product from the oven. During this observation of the tray line Diet Aide #19 was not wearing a beard restraint as they served soup. Diet Aide #20 used gloved hand to pick up steak fries to place onto the plate and pushed vegetables onto the plate, then wiped brow with gloved hand. During an interview with the Assistant Food Service Director at the time of the observation, they stated the staff needed a lot of retraining and supervision. They asked Diet Aide #19 to step away from the tray line to don a beard restraint and wash hands and Diet Aide #20 to use tongs to pick up food and don new gloves. 3) During an observation of the C1 Dining Room Pantry Refrigerator on 5/13/25 at 12:26 PM the refrigerator temperature log was blank from 4/29/25-5/12/25 and documented on 5/13/25 at 10:12 AM the refrigerator was 36 degrees, and the freezer was -2 degrees. The refrigerator contained multiple open items with no dates including juice bottles, applesauce, a pizza box, and guacamole. There were two sandwiches dated 5/5/25, for Residents #54 and #211. There was personal food for Resident #10 dated 5/1/25, and multiple Yoplait yogurts with an expiration date of 3/18/2025. During an interview on 05/13/25 at 1:05 PM, Licensed Practical Nurse Unit Manager #6 stated that it was the responsibility of food services to monitor and check the temperatures of the freezer and refrigerator. Nursing and food services were both responsible for checking the contents of the refrigerator. They stated that the refrigerator contained many items that needed to be discarded, and the temperature log was incomplete. 10 NYCRR 415.14(h)

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	335451	A. Building B. Wing	05/20/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review completed during a Recertification survey from 5/13/25-5/20/25 the facility did not ensure provision of a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for one (Resident #167) of five (5) residents reviewed for Pressure Ulcers. Specifically, Resident #167 who had a Pressure Ulcer and a Chronic Vascular ulcer with Physician ordered dressing changes was not placed on enhanced barrier precautions (interventions designed to reduce transmission of multi-drug-resistant organisms including gown and glove use during high contact resident care activities) and staff did not wear proper personal protective equipment (gowns) during care while completing wound dressing changes. The finding is: A Policy and Procedure titled Enhanced Barrier Precautions dated 4/24 stated, the use of gowns and gloves for high-contact resident care activities is indicated for nursing home residents with wounds and or indwelling medical devices. Resident #167 had diagnoses including Diabetes, Dementia, and a pressure ulcer to left buttock. The 4/6/25 quarterly Minimum Data Set (assessment tool) documented the resident's cognition as moderately impaired. The resident required partial to moderate assist with eating, substantial to moderate assist with toilet hygiene, and partial to moderate assist with all other activities of daily living. The resident was documented as having one Stage 3 pressure ulcer. During observations on 05/14/25 at 10:45 AM and 05/15/25 at 9:01 AM, the resident was noted in bed asleep. There was no Enhanced Barrier Precautions sign on the door. During an observation and interview on 05/15/25 at 1:55 PM of wound care for both buttock, and left heel dressings changes, the Infection Preventionist stated the resident was not on Enhanced Barrier Precaution because the wounds were not draining. The Infection Preventionist and Licensed Practical Nurse Unit Manager #10 did not don a gown prior to changing the resident's dressing. The electronic medical record did not document a Physician's order or a care plan for Enhanced Barrier Precautions. During an interview with the Infection Preventionist on 05/15/25 at 1:26 PM, they stated they made a mistake, and the resident should have been on Enhanced Barrier Precautions. They stated they should have worn a gown when changing the resident's dressing. 10 NYCRR 415.19(a)(2)