STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER: Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2535 Genesee Street, Utica, NY 13501	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 48052 Based on observations and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups were posted in a form and manner accessible to residents and resident representatives. Specifically, 13 out of 13 anonymous residents present at the resident group meeting stated they did not know where to find the Ombudsman and New York State Nursing Home Complaint Hotline information. Additionally, there were no posted Ombudsman program or New York State Nursing Home Complaint Hotline numbers or posters observed in the facility. The findings include: The facility policy Resident Rights, dated 10/2017, documented the facility posted the names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups which included State Survey Agency, the Ombudsman, and the Medicaid Fraud Control Unit in a manner and form accessible and understandable to all residents and the resident representatives. The posting also contained a statement that the resident may file a complaint with the State Survey Agency concerning any violation of state or federal nursing facility regulation. During a resident group meeting on 2/3/2025 at 1:46 PM, 13 anonymous residents stated they did not know where to locate the contact information for the Ombudsman or the New York Nursing Home State Complaint Hotline. There were no New York State Nursing Home Complaint Hotline or Ombudsman Program postings observed: - on 2/3/2025 at 2:44 PM and 2/10/2025 at 3:54 PM in the main lobby. - on 2/5/2025 at 9:52 AM, 2/6/2025 at 9:34 AM, and 2/7/2025 at 12:57 PM on the 4th floor. During an interview on 2/07/2025 at 1:05 PM, the Social Services Director stated the New York State Nursing Home Complaint Hotline number, and the Ombudsman contact information were in the resident handbook given on admission. The signs for the State Complaint Hotline and the Ombudsman were not re-posted since the renovation. They were aware access to the numbers for both the State Complaint Hotline and the Ombudsman was a resident right. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/10/2025 at 12:49 PM, the Administrator stated during the facility's construction process the signs for the New York State Nursing Home Complaint Hotline and the Ombudsman were taken down. The signs they had were water damaged from being in storage or were missing. They were in the process of ordering some more signage and received new Ombudsman posters the week before, but they were not put up. They made paper versions of the signs and hung them up, but they were taken down either when the construction moved to that area or by residents on those halls. They stated it was important for the residents to have access to the New York State Nursing Home Complaint Hotline and the Ombudsman contact information because it was a resident right. 10 NYCRR 415.3 (d)(2)(i)(b)

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48052 Based on observations and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure the results of the most recent Federal and State surveys were posted in a place readily accessible where individuals who wished to examine the survey results did not have to ask for them. Specifically, the facility state inspection binder located in the front lobby did not include the most recent (3/3023) standard health survey results and any subsequent complaint survey results, and there was no posted notification of the availability of the previous 3 years of survey reports. Findings Include: The facility policy, Resident Rights, dated 10/2017, documented the residents had the right to examine the reports of any surveys, certifications, and complaint investigations made regarding the facility during the 3 proceeding years which included any plans of correction. The results were posted in a place that was readily accessible to residents, family members, and legal representatives. The facility posted the notice of availability of such report in a prominent and accessible area of the facility. The following observations were made of the facility state inspection binder: - on 2/4/2025 at 2:16 PM The New York State inspection results were at wheelchair height in a labeled black half inch binder in the lobby next to the receptionist. The binder contained the 3/7/2023 Life Safety survey results. There were no health survey results from 3/2023 or subsequent complaint survey results in the binder. There was no posted notification of the availability of survey reports during the 3 preceding years. - on 2/10/2025 at 11:23 AM The New York State inspection results were in the lobby on the side of the front desk. The book contained the star rating for the facility from the Medicare website and the statement of deficiencies with plan of correction for the 3/7/2023 Life Safety survey. There were no health survey results from 3/2023 or subsequent complaint survey results in the binder. There was no posted notification of the availability of survey reports during the 3 preceding years. During an interview on 2/10/2025 at 11:24 AM, Receptionist #20 stated the New York State inspection black half inch binder was the only binder they had that contained the state inspections. They were only in charge of making sure the binder was on the counter, not of the contents inside the binder. At 12:19 PM, they stated the Administrator was responsible for the contents of the binder. During an interview on 2/10/2025 at 12:49 PM, the Administrator stated the binder that contained the state inspections was their responsibility. They had just added the last complaint results recently, the star rating to the book within the last week and had verified all the correct information was in there. They only checked the binder when they added or changed information in the binder. The binder should include the last survey results and anything in-between that date and the next survey. 10NYCRR 415.3(1)(c)(1)(v)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35045 Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for 3 of 5 resident units (Units 2 North, 2 South, and 3 South) reviewed. Specifically, the stove/oven in Unit 2's activity room had accessible and operational knobs; Resident #31 on Unit 3 had an unclean tube feeding pole; and Resident #6 on Unit 4 had an improperly secured enabler bar (a device attached to the bed to aid in positioning). Findings include: The facility policy, Resident Rights dated 10/2017, documented the facility would maintain a safe, sanitary, clean, comfortable and homelike environment for the residents. The facility policy, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 5/2023, documented resident care equipment, including reusable items and durable medical equipment would be cleaned and disinfected according to current Center for Disease Control recommendations for disinfection and the Occupational Safety and Health Administration Bloodborne Pathogens Standard. Unit 2- Teresian Room/Oven The following observations were made on Unit 2 in the Teresian Room: - On 2/2/2025 at 12:27 PM, there was a stove with an artificial plant in the middle of the four burners. The stove was operational and became hot when the knobs were turned on. - On 2/3/2025 at 2:42 PM, an activity was taking place in the Teresian room with 2 activity staff present. The stove was plugged in, and the burners were hot when tested . From 5:51 PM- 6:06 PM, the Teresian room doors were closed and unlocked. - On 2/4/2025 at 1:58 PM, the Teresian room was in use by residents and staff playing bingo. The oven was used and there were cookies on a baking pan on top of the stove. - On 2/4/2025 at 3:51 PM, the Teresian room door was closed and unlocked. There were baked cookies on top of the stove. There were no staff or residents in the room. During an interview on 2/5/2025 at 3:15 PM, the Director of Activities stated the second floor Teresian room was the main activity room. The room was never locked, but the doors were closed between 4:00 PM and 5:00 PM, when the activity staff left the facility. The oven and stove were used by the facility activity staff during baking activities. The oven was always plugged in and ready to be used. The activity room was not locked because the door in the back of the Teresian room was the fire exit. Residents were not permitted to go in the Teresian room unless there was staff present. They stated the residents had access to the room since it was unlocked and the plugged in stove/oven could be unsafe if residents entered the room unsupervised. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 5:10 PM, the Director of Environmental Services stated the stove was not a safety stove/oven. It was accessible to staff and residents, and they were not aware of any safety features. This stove/oven was installed with the facility renovations. The oven doors did not have a safety lock. Unit 3 -Unclean Resident Medical Equipment Resident #31's tube feeding pole (used to hold tube feeding formula) was observed with a large amount of splattered, tan residue on the base and lower portion of the pole: - on 2/3/2025 at 10:36 AM, - on 2/4/2025 at 9:56 AM, - on 2/4/2025 at 2:51 PM, - on 2/5/2025 at 11:24 AM. During an interview on 2/5/2025 at 12:38 PM, Licensed Practical Nurse Unit Manager #15 stated housekeeping was responsible for keeping equipment clean, including tube feeding poles, but nursing should clean them if needed. Resident #31's pole was unclean and could be growing bacteria. Anyone who noticed it was dirty should have cleaned it. It was undignified for the resident to have dirty equipment. During an interview on 2/5/2025 at 1:50 PM, Housekeeper #6 stated every resident room was cleaned every day and included the cleaning of equipment poles. They cleaned Resident #31's room two days ago and did not notice the pole was dirty. They noticed it today and planned to clean it. It was important to keep poles clean to keep the germs off. During an interview on 2/7/2025 at 2:35 PM, the Director of Environmental Services stated resident rooms were cleaned every day and included equipment poles. In between cleaning they should be wiped down by nursing or environmental services. It was a joint effort to keep equipment clean. If nurses spilled something on a pole, they expected them to wipe it up. It was important to keep equipment clean for infection prevention purposes. Unit 4- Resident Enabler Bar Not Maintained Resident #6's Comprehensive Care Plan initiated 12/27/2023 documented the resident had an activities of daily living self-care deficit related to limited mobility. Interventions included limited assistance of 1 for bed mobility, bed with bilateral enabler bars. The following observations were made: - on 2/3/2025 at 10:20 AM, Resident #6 was in bed watching television. Their enabler bar on the window side of the bed was not connected to the bed. The bar moved up and down and was not tight to the frame. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 2/5/2025 at 9:42 AM, Resident #6's enabler bar on the widow side of the bed, had black electrical tape wrapped around the curve of the bar. The bar was not in the upright position. The bottom of the enabler bar was missing a bolt to keep it in the up position. Resident #6 stated the bar was broken, and the staff were aware that it was broken. - on 2/6/2025 at 8:57 AM, Resident #6's enabler bar was missing the bolt and was not connected to the bed. The enabler bar was hanging down on the side of the bed and unable to be used. - on 2/7/2025 at 12:56 PM, the enabler bar on the window side of the bed was not connected to the bed and unable to be used. Facility work orders dated 8/11/2024-2/7/2025 did not include an open or completed work order for Resident #6's broken/or unsecure enabler bar. During an interview on 2/7/2025 at 2:04 PM, Maintenance Worker #42 stated they were made aware of work orders or broken equipment through a computerized work order program. They did not receive a work order for Resident #6's enabler bar. Maintenance worker #42 observed Resident #6's enabler bar on the window side of the bed, and stated the bar was not attached. They stated the bar could not be used if it was not properly attached to the bed. During an interview on 2/7/2025 at 2:26 PM, Certified Nurse Aide #7 stated they noticed Resident #6's enabler bar was not attached on one side and it had been that way for a while. They did not submit a work order because sometimes residents had one bar on and one bar off. During an interview on 2/10/2025 at 10:31 AM, Registered Nurse Unit Manager #28 stated staff could put work orders in the computer when something needed to be repaired. They were not aware of Resident #6 enabler bar not being attached to the window side of the bed. They said that was the resident's strong side and the enabler bar should be in place for safety. During an interview on 2/10/2025 at 1:44 PM, the Director of Environmental Services stated they inspected beds biannually, and the enabler bars were part of the inspection. They did not have a record of request to fix Resident #6's enabler bar. All the beds were inspected in September 2024. Resident #6's bed was inspected on 9/3/2024 and there no side rails or enabler bars in place. 10 NYCRR 415.29(j)(1) 48052 50561

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

48052

Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure a process was in place for residents to have their grievances addressed for 13 of 13 anonymous residents present at the resident group meeting. Specifically, all 13 residents stated they did not know who the grievance officer was or how to file a grievance.

Findings include:

The facility policy, Grievances, revised 2/2020, documented residents had the right to voice their grievances and concerns with the expectation of resolution. The Director of Social Services or the resident's social worker was designated as the Grievance Official. A copy of the grievance policy was provided upon admission. Information on how to file a grievance was given upon admission and was prominently posted in locations throughout the facility. Specific information to be included was the right to file a grievance anonymously, contact information for the grievance official with whom the grievance could be filed, a reasonable timeframe, the right to obtain a written decision, and independent entities for which a grievance could be filed such as the pertinent State Agency, Quality Improvement organization, and the Ombudsman.

During a resident meeting on 2/03/2025 at 1:46 PM, 13 of 13 anonymous residents stated they were unsure of who the grievance officer was, did not know how to file a grievance, and were not given the facility's grievance policy.

During an interview on 2/07/2025 at 1:05 PM, the Social Services Director stated they were the Grievance Officer, and it was communicated to residents through the handbook they received at admission. Residents filed a grievance by the Social Services Director going to speak with the resident and asking them if they wanted the Social Services Director to fix the issue or file a formal grievance. The only way a resident was able to file a grievance was by talking to the Social Services Director. If a resident wanted to file a grievance anonymously, the Social Services Director would not put their name on the form. They were aware it was a resident's right to file grievances anonymously and if a resident wanted to file a grievance anonymously and exclude them as well, they had the complaint hotline number they could call.

During an interview on 2/10/2025 12:49 PM, the Administrator stated if a resident wanted to file a formal grievance, they went to the Social Services Director who was the Grievance Official. A form was filled out and then it went to the responsible department head. The grievance was not closed until all departments involved provided an answer to their part of the grievance. If the Social Services Director was not available, Social Worker #38 was responsible for grievances. Any supervisor could also take a complaint and inform the Social Services Director of the issue for a grievance. The residents knew who the Grievance Officer was as it was listed in the welcome packet. They stated they did not have signs that listed who the grievance officer was or how to file a grievance. They did not know how residents who did not have resident handbook were aware of how to file a grievance or who the grievance officer was. They did not know how a resident would file a grievance anonymously and was not aware it was a resident right to be able to file a grievance anonymously.

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	335471	A. Building B. Wing	02/11/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10NYCRR 415.3(C)(1)(ii)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35045 48052 49448 Based on record review and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 3 of 5 residents (Residents #59, #88, and #100) reviewed. Specifically, Resident #59's person-centered comprehensive care plan did not include the diagnoses of type 2 diabetes mellitus (the body does not use insulin properly causing high blood sugars) or the use of insulin (used to treat high blood sugars); Resident #88's person-centered comprehensive care plan did not include use of an anticoagulant (blood thinner); and Resident #100's person-centered comprehensive care plan did not include the diagnoses of diabetes or the use of insulin, anticoagulant, or psychotropic (used to treat mood/ behaviors) medications. Findings include: The facility policy, Comprehensive Care Planning, revised 2/2019, documented an individualized or person-centered comprehensive care plan was initiated by a registered nurse upon admission for all residents. The comprehensive care plan included measurable objectives that met the resident's medical, nursing, and psychosocial needs identified from admission assessments, and the Minimum Data Set assessments (a health status tool). The interdisciplinary team reviewed and revised care plans quarterly after the Minimum Data Set assessment was completed, with a significant change, following hospital return, annually, and as needed. Appropriate care plans were initiated based on nursing assessment findings and medical conditions. 1) Resident #59 had diagnoses including type 2 diabetes mellitus with hyperglycemia (high blood sugar). The 1/9/2025 Minimum Data Set assessment documented the resident was cognitively intact, had medically complex conditions, and received daily insulin injections. Physician orders documented the following orders for diabetes mellitus: - On 3/22/2023 metformin hydrochloride (regulates blood sugar) 1000 milligrams orally twice a day. - On 3/24/2023 Tresiba (long-acting insulin) 20 units subcutaneous (given in the fatty tissue under the skin) injection at bedtime. - On 12/19/2024 Insulin Lispro (short acting insulin) 22 units subcutaneous injection three times a day. - On 1/1/2024 weekly fingerstick (to test blood sugar levels) before meals and at bedtime. Call provider if blood sugar was lower than 60 or higher than 450. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

- On 1/24/2025 Ozempic (helps manage blood sugar) 1 milligram subcutaneous injection every Friday.

A 10/24/2024 at 7:29 PM Nurse Practitioner #46 progress note documented the resident's A1C (a blood test that measures the average blood glucose over the past 2-3 months) level was maintained at the recommended level. Interventions included educate the resident and caregivers on signs and symptoms of hypoglycemia and appropriate management of symptoms related to diabetes.

There was no documented evidence of a person-centered comprehensive care plan that included the diagnosis of diabetes with the need for insulin administration and oral diabetic agents, and monitoring for hyperglycemia and hypoglycemia (low blood sugar).

During an interview on 2/10/2025 at 9:46 AM, Certified Nurse Aide #12 stated they were not sure what diabetes was but thought it had to do with sugar. If a resident was diabetic, it might be on their plan of care. They were supposed to reference the plan of care daily. They were not sure if Resident #59 was diabetic or what specifically they should monitor the resident for.

During an interview on 2/10/2025 at 9:56 AM, Licensed Practical Nurse #4 stated if a resident was diabetic, it should be on their care plan because it indicated how to care for that resident. Insulin was a high-risk medication and too much insulin could drop the blood sugar and not enough could cause higher blood sugars. The Unit Manager was responsible for updating the care plans.

During an interview on 2/10/2025 at 10:53 AM, Licensed Practical Nurse Unit Manager #15 stated Resident #59 was a diabetic and was on insulin. The resident did not have a diabetic care plan and should. The initial assessment should have triggered a diabetic care plan. The care plan would carry over to the care instructions for the certified nurse aides to know what signs and symptoms to monitor for. Care plans were reviewed quarterly, and they were not sure why this was missed for nearly two years. They reviewed care plans at the care plan meetings and at the weekly risk meetings.

2) Resident #88 had diagnoses including atrial fibrillation (irregular heartbeat). The 12/20/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required partial/moderate assistance with most activities of daily living, had one fall with injury, and was on an anticoagulant.

The 5/29/2024 physician order documented Eliquis (blood thinner) 2.5 milligram tablet by mouth two times a day for atrial fibrillation.

There was no documented evidence of a person-centered comprehensive care plan that included the use of an anticoagulant for a diagnosis of atrial fibrillation and monitoring for symptoms of anticoagulant use.

During an interview on 2/10/2025 at 9:41 AM, Licensed Practical Nurse #26 stated if a resident was on an anticoagulant, the resident was monitored for bruising. They stated they did not know how to look at a care plan and if they had a question regarding the resident's care, they asked the certified nurse aides.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/2025 at 10:31 AM, Registered Nurse #28 stated use of an anticoagulant medication should be on the care plan, so staff knew to look for signs of bleeding or bruising. These residents were more fragile. Most of the care plans were initiated upon admission. They tried to update them during care planning meetings. Resident #88 came from another floor, so they did not catch there was not a care plan for anticoagulant use. 3) Resident #100 had diagnoses including diabetes mellitus, long term use of insulin, Parkinson's disease (a progressive neurological disease), and atrial fibrillation (irregular heartbeat). The 1/1/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, did not exhibit behaviors, had medically complex conditions, was on an anticoagulant, received daily insulin injections and was on an antipsychotic since admission and a gradual dose reduction was documented as clinically contraindicated on 11/18/2024. Physician orders documented: - On 10/2/2024 Eliquis 5 milligram tablet by mouth twice daily for atrial fibrillation and fingerstick four times a day for diabetes mellitus monitoring. Contact provider if blood sugar less than 60 or greater than 450. - On 10/3/2024 dapagliflozin propanediol (used to control blood sugar) one 10 milligram tablet by mouth once a day for diabetes mellitus. - On 11/6/2024 Lantus (long-acting insulin) 10 units subcutaneously once daily for diabetes mellitus. - On 11/13/2024 quetiapine (antipsychotic) 25 milligram tablet, two tablets by mouth at bedtime for behaviors. - On 11/14/2024 quetiapine 25 milligram tablet by mouth once daily for behaviors. - On 11/26/2024 Bydureon (injectable, used to control blood sugars) 2 milligrams subcutaneously once daily on Tuesdays for diabetes mellitus. There was no documented evidence of a person-centered comprehensive care plan that included the use of an anticoagulant for a diagnosis of atrial fibrillation, the use of antipsychotic medications, or the diagnosis of diabetes with the need for insulin administration. During an interview on 2/7/2025 at 1:22 PM, Registered Nurse Unit Manager #36 stated they did not know if high-risk medications should be included in the care plan. High risk medications were important to be reviewed. If a resident was on a blood thinner and they fell , they could bleed. Psychotropic medications would be important to ensure behaviors were appropriately monitored. Insulin was important to ensure blood sugars were appropriately managed as they effected the entire body system. Resident #100 was on high-risk medications including an anticoagulant, psychotropic, and insulins and probably should be care planned for these medications because the care plan indicated interventions to care for the resident. The Minimum Data Set nurse was responsible to ensure care plans were initiated on admission and after care plan meetings. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Utica Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2535 Genesee Street Utica, NY 13501	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/2025 at 9:44 AM, Minimum Data Set Licensed Practical Nurse #31 stated high risk medication care plans were initiated by the registered nurse Unit Managers, and they only completed the triggered portions. Care plans were discussed during the interdisciplinary team meetings. The purpose of a care plan was to ensure staff knew what care the resident needed, medications taken and potential side effects, and any disorders so the appropriate resident care was provided. High risk medications should have been included in the care plan because they required monitoring. During a telephone interview on 2/10/2025 at 11:43 AM, the Interim Director of Nursing stated the Nurse Managers were responsible for care plans, but the entire interdisciplinary team was involved. High risk medications such as insulin, anticoagulants, and psychotropics should be updated by nursing. The care plan should be reflective and alert staff for interventions or approaches to be implemented. A licensed practical nurse Unit Manager could update the care plan, but a registered nurse needed to initiate the care plan. During the care plan meetings staff should review diagnoses and medications to ensure the care plan was current and up to date. 10NYCRR 415.11(c)(1)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

35045

Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility failed to ensure the resident environment was free of accident hazards for three (3) of eight (8) residents (Residents #72, #75, and #98) reviewed. Specifically, Residents #72, #75, and #98 were served and Residents #72 and #98 consumed a cleaning solution stored in the kitchenette refrigerator in an unlabeled pitcher. This resulted in physical and psychosocial harm to Resident #72 that was Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm, serious impairment, serious injury, or death to Residents #72, #75, and #98 and the additional 107 residents in the facility.

Findings included:

The facility policy, Food Receiving and Storage, dated 6/12/2023, documented foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer would be covered, labeled, and dated with use by date. Pesticides and other toxic substances and drugs should not be stored in the kitchen area or in the storerooms for food or food preparation equipment and utensils. Soaps, detergents, cleaning compounds, or similar substances should be stored in separate storage areas from food storage and labeled clearly.

The Safety Data Sheet (a fact sheet describing the chemical properties of a product) for Orange-multipurpose cleaner/degreaser documented the chemical may cause eye and skin irritation. Acute hazard effects with ingestion may include irritation to the mouth, throat, and gastrointestinal system. Symptoms include nausea, vomiting, diarrhea, and cramps. The chemical should be stored in an original container, away from direct sunlight in a dry, cool and well-ventilated area, away from food and drinks.

1) Resident #72 had diagnoses including end stage renal (kidney) disease, hypertension (high blood pressure), and diabetes. The 11/28/2024 Minimum Data Set assessment (health screening tool) documented the resident was cognitively intact and required set up or clean up assistance with eating.

The 9/18/2024 comprehensive care plan documented the resident required set up by staff to eat their meals.

The 1/27/2025 at 6:30 PM Interim Director of Nursing progress note documented the resident inadvertently ingested a gulp of a diluted cleaning solution. The resident was assessed with no complaints of pain, denied any nausea or vomiting, vital signs were stable and there were no concerns other than the resident stated they had a terrible taste in their mouth.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 1/27/2025 Resident Accident/Incident Report for Resident #72 completed by the Interim Director of Nursing documented that on 1/27/2025 at 5:30 PM, Resident #72 was in the dining room and was inadvertently served a cup with a cleaning solution in it. The resident did not consume the entire cup, took a gulp and realized something was wrong. The incident was not witnessed. The resident was assessed without injury. The Medical Director and Poison Control were contacted for further directions. Upon investigation it was determined a pitcher was brought up from the kitchen that appeared to be a diluted mixture of an orange cleaner. As soon as it was identified, staff immediately assessed all the drinks that were served and found three (3) cups with suspect liquid. Residents were assessed with no negative findings or signs and symptoms of psychological harm. Resident #98 took a sip and immediately spit it out and stated it did not taste good. Resident #75 did not drink any of the liquid and had a full cup in front of them. The pitchers were not labeled. Staff education was done regarding proper mixing of chemicals and proper storage and labeling of pitchers. A full house audit was immediately conducted to ensure all pitchers were properly labeled and no other pitchers contained the mixture. The incident was not reported to the Department of Health. The investigation concluded there was no cause to believe resident abuse or mistreatment occurred. The investigation was signed by the Administrator on 2/4/2025. Nurse Practitioner progress notes for Resident #72 documented: -On 1/28/2025 at 9:45 AM Nurse Practitioner #30 documented a late entry progress note. On 1/27/2025 the resident inadvertently ingested a gulp of a diluted cleaning solution. The resident was assessed with no complaints of pain, denied nausea/vomiting, vital signs were stable. The resident had no concerns other than a terrible taste in their mouth. The Medical Director was updated. Nurse Practitioner #30 documented they were made aware on 1/28/2025. Poison control was called after the incident and continued monitoring was recommended. No acute abnormalities and the resident was asymptomatic. -On 1/29/2025 by Nurse Practitioner #30, the resident was complaining of intermittent nausea without vomiting or diarrhea. The resident was examined, and physical exam demonstrated no acute abnormalities. Labs were ordered and they included complete blood count, comprehensive metabolic panel, ammonia, magnesium, lipase, and amylase. -On 1/30/2025 by Nurse Practitioner #32, the resident was referred to them by the Nurse Manager. The resident had an incident, and they accidently swallowed some cleaning fluid. The resident did express some anxiety after the incident, but there were no serious consequences reported. -On 2/3/2025 by Nurse Practitioner #30, the resident complained to the nursing staff of having an intermittent sore throat. The resident stated they had an intermittent sore throat during meals for the last 24 hours. The resident's sore throat was intermittent, and they declined medications for the sore throat. -On2/4/2025 by Nurse Practitioner #30, the resident no longer complained of a sore throat. If they developed dysphagia (difficulty swallowing, respiratory compromise/distress), they would recommend a swallow evaluation, chest x-ray, and diet downgrade. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/5/2025 at 4:44 PM, Resident #72 stated on 1/27/2025 they were in the dining room eating. They picked up what they thought was apple juice and it was a little on the yellow side, but they did not think there was anything wrong with it. They took a big swallow, and their mouth burned and was sore. After they swallowed the liquid, they thought it tasted terrible and was spoiled. They stated since then their mouth was sore on and off and it was very hard to swallow because it hurt, but it was getting better. Since then, they only took small sips of fluids instead of taking a full swallow because they were little fearful when drinking. No one told them the liquid was cleaning solution. They stated they were really scared after they drank it because they felt really yucky, and they told the others not to drink it. 2) Resident #75 had diagnoses including hypertension and gastroesophageal reflux disease (acid backup into the esophagus). The 12/4/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and required set up and clean up assistance with eating. The 9/24/2024 comprehensive care plan documented the resident required limited assistance for eating. The 1/27/2025 at 6:30 PM, Interim Director of Nursing progress noted documented the resident received a cup with a diluted cleaning solution in the cup. They were unable to determine if any had been consumed by the resident. The cup appeared to be full at the time it was removed from the resident. The 1/27/2025 Resident Accident/Incident Report for Resident #75 completed by the Interim Director of Nursing documented on 1/27/2025 at 5:30 PM Resident #75 was served a cup of liquid containing cleaning solution. The cup did not appear to have any of its contents gone and was removed immediately. The resident was unable to state their version of the event. The resident was assessed without negative findings. The Medical Director and Poison Control were notified, and the plan was to follow recommendations. Staff were educated regarding proper mixing and storage of chemicals and labeling of pitchers. The 1/28/2025 Nurse Practitioner #22 progress note did not include documented evidence they were notified the resident was served a cup containing cleaning solution or the resident was evaluated for possible side effects. 3) Resident #98 had diagnoses including dementia and anxiety. The 1/2/2025 Minimum Data Set assessment documented the resident had severely impaired cognition and required set up and clean up assistance with eating. The 7/3/2024 comprehensive care plan documented the resident required supervision for eating. The 1/27/2025 at 6:30 PM, Interim Director of Nursing progress note documented the resident received a cup of liquid that contained diluted cleaning solution. The resident stated they took a sip but did not swallow it because it tasted funny. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The 1/27/2025 Resident Accident/Incident Report for Resident #98 completed by the Interim Director of Nursing documented on 1/27/2025 at 5:30 PM Resident #98 was inadvertently served a cup of liquid that contained cleaning solution. The resident stated they only took a sip but did not swallow the liquid because it tasted awful. The resident was assessed without negative findings. The Medical Director and Poison Control were notified, and the plan was to follow recommendations. Staff were educated regarding proper mixing and storage of chemicals and labeling of pitchers. The 1/28/2025 Nurse Practitioner #22 progress note documented the resident had chemical exposure, appears to adverse events, staff did assist and would continue to monitor. Investigative written statements for the incident involving Residents #72, #75, and #98 included: -On 1/27/2025 at 6:30 PM, Dietary Supervisor #35 documented they were checking the floor to make sure they were fine serving. They went to the 3rd floor and noticed the juice looked odd. They thought it looked like cranberry ginger ale. They smelled the liquid, and it had a chemical smell. They checked all the cups, and some residents had some of the liquid and Resident #72 said they drank it. They reported the occurrence to Licensed Practical Nurse #2. -On 1/27/2025 at 7:57 PM, Food Service Aide #34 documented they went upstairs to pour drinks; the liquid was in a juice container in the refrigerator along with other drinks. They did not remember it being there that morning. They assumed it was juice, poured the liquid, it looked like a light apple juice or cranberry mix, and put it on the cart with the other juices. They did not notice a scent. The container was not labeled or dated. They thought it was a new pitcher since it was not there that morning. The summary of the 1/27/2025 investigation reviewed on 2/4/2025 by the Administrator documented there was concern that possible cleaning solution was served to the residents at dinner on the third floor. Upon investigation, it was determined that a pitcher was brought up from the kitchen that appeared to be, based on its color and odor, a diluted mixture of Orange Cleaner. The staff immediately assessed all the drinks that were served to find three (3) cups with suspicious liquid which were immediately removed. The residents were assessed and there were no negative findings or signs and symptoms of psychological harm. The pitcher used to serve the liquid was not labeled. Staff education was done regarding proper mixing of chemical and proper storage and labeling of pitchers. A full house audit was immediately conducted to ensure all pitchers were properly labeled and no other pitchers were found with this mixture. Poison Control was contacted, and the Administrator and Medical Director were made aware. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/5/2025 at 10:12 AM, Food Service Aide #34 stated they worked on the third-floor dining room on the evening of 1/27/2025. They worked the 6:30 AM - 2:30 PM shift and then came in at 4:00 PM for extra time. They were not sure how cleaning fluid got into the juice pitcher. They took pitchers from the main kitchen downstairs and filled them up with juice in the main kitchen and brought them up to the dining room for meals. They stated on 1/27/2025 they went to the third floor kitchenette refrigerator to get more juice, and they poured six (6) mini cups of juice from the pitcher. They stated this was not a pitcher they put in the refrigerator during the day, and it looked like a mix of cranberry and apple juice. Certified nurse aides sometimes mixed the juices. They did not smell it, but the pitcher did not have a label on it and usually everything was labeled. They stated they should not have poured from the unlabeled pitcher. They stated the Dietary Cook/Supervisor #35 came to the unit to check on staff and asked what was in the pitcher as it looked like it had bubbles in it, and it smelled like soap. Food Service Aide #34 stated all cleaning products should stay in their original containers, and it was not safe to place chemicals into food service containers/pitchers. During an interview on 2/5/2025 at 11:08 AM, Dietary Cook/Supervisor #35 stated on 1/27/2025 they checked on the staff in all three dining rooms, and when they went to the 3rd floor, they asked the food service aide what was in the pitcher, because it looked funny. They stated it smelled like chemical cleaner. They reported this to the nursing staff and all the cups of juice were removed. Resident #72 had already drank some of the liquid. They told all food service aides to check the drinks in the refrigerator to ensure they were labeled and to get rid of anything unlabeled. Cleaning products should all have their own containers. All juice pitchers should be labeled and dated. If the pitcher was not labeled staff should pour it out. They found the pitcher used to pour the chemical under the coffee cart, the interim Director of Nursing removed it from the floor, brought it to the kitchen and began an incident report. They did not know how the cleaning product got in the refrigerator. During an interview on 2/5/2025 at 11:55 AM, the Food Service Director stated food service staff called them and reported they found liquid, believed to be diluted Orange cleaner in cups that were served to residents. They were not sure how a cleaning product ended up in a juice pitcher. The juice pitchers were clear and should have lids. Food service staff were required to dispense juice from the kitchen into pitchers, label the pitchers with the type of juice and the date, and put a lid on the pitcher before they were delivered to the units. They stated the food service aide should not have served this liquid to the resident because it did not have a label. Food Service Aide #34 received training on 1/29/2025 about cleaning products and food safety. During a telephone interview on 2/5/2025 at 4:30 PM, the Medical Director stated they were made aware on 1/27/2025 during the evening meal that three (3) residents were served cleaning solution as juice. They were not sure how this happened and told the Director of Nursing to call Poison Control. Housekeeping and maintenance should oversee where cleaning chemicals were stored, and they should be labeled, and in the appropriate containers. Cleaning products should not be in a refrigerator. They stated it could be harmful for a resident to swallow a cleaning chemical. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 2/5/2025 at 4:42 PM, the Administrator stated they were made aware of the incident on the evening of 1/27/2025 when three (3) residents ingested a cleaning chemical. The three residents were assessed that night and found to be okay. Nursing staff called Poison Control and Resident #72 was seen by the doctor every day to monitor. The Administrator stated they were not updated as to what the chemical was. Housekeeping should store chemicals in locked closet. All cleaning supplies should be behind locked doors and labeled. If nursing staff found food or drink items in an unlabeled container they should throw it away. Cleaning chemicals should not be stored in a refrigerator. The Interim Director of Nursing did an in-service that night on storage and mixing of chemicals and all the dietary staff received the education. They were unsure what the liquid was, and they still had not figured out how a cleaning product got in the kitchenette refrigerator.

During an interview on 2/5/2025 at 4:51 PM, the Interim Director of Nursing stated on 1/25/2025 they received a call from nursing staff that residents were served cleaning solution during the evening meal. They went to the unit and had all beverages removed from the dining room. They went back through the dining room and looked at all the pitchers and pulled all poured drinks off the tables. They assessed all three (3) residents. There was no evidence Resident #75 drank the liquid, Resident #98 said they spit it out, and Resident #72 said they took a gulp of the liquid, and it did not taste right. Dietary Cook/Supervisor #35 pulled and dumped all the pitchers. They called the Medical Director and Poison Control. They did not have pictures of the pitcher, but it looked like the Orange cleaning solution but a lighter color. The residents did not have access to the kitchenettes, only nursing and food service staff did. If staff found an unlabeled container of liquid in a pitcher it should not be served and should be discarded. The Poison Control center said the Orange chemical was not likely to cause harm. They stated they were 100% sure the liquid was Orange cleaner because they smelled it, and it had a very distinct smell. They were unable to determine how the liquid got into the unit refrigerator.

10 NYCRR 415.12(h)(1)(2)

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Immediate Jeopardy was identified, and the facility Administrator was notified on 2/6/2025 at 2:49 PM. The facility Administrator was notified on 2/7/2025 at 4:10 PM, that Immediate Jeopardy was removed on 2/7/2025 at 3:28 PM based upon the following corrective actions taken:

- On 2/6/2025 at 6:38 PM, the Administrator provided an immediacy removal plan that was initiated on 2/6/2025 at 5:38 PM when all the chemicals were removed from the kitchenettes and secured in the locked service closet on the first-floor service corridor. All food service staff were to be educated on the process of taking cleaning chemicals from the secured chemical closet after meal service to clean the kitchenettes, and no chemicals were to be left in the kitchenettes. All staff were educated that any unlabeled drinks were to be disposed of immediately. The Certified nurse aides, food service staff, licensed practical nurses, and registered nurses were educated with emphasis on the fact drinks were to be identified with a label and date. The facility would educate 100% of staff prior to the start of their next scheduled shift.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On 2/7/2025 at 5:30 AM, the Dietary Cook/Supervisor completed an audit of all three kitchenettes to ensure there were no unsecured cleaning agents, or unlabeled drinks. At 9:00 AM, the Director of Food Services completed floor round and confirmed there were no chemical bottles in the kitchenettes, at 10:11 AM, the Food Service Director completed an audit of the first-floor kitchen and removed unsecured cleaning agents and placed them in the locked first floor corridor kitchen closet. At 10:47 AM, 86 of 147 employees (59%) were educated and the plan was to continue to educate employees over the phone and prior to their next scheduled shift. - On 2/7/2025 at 3:28 PM, 85% of staff, 125 had been educated about storing cleaning products in the kitchen and kitchenettes, labeling all resident drinks in pitchers with the date and juice type, and immediately disposing of anything unlabeled in a pitcher.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40803 Based on observation, record reviews, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for 2 of 3 residents (Residents #6 and #31) reviewed. Specifically, clinical nutrition staff did not assess Resident #6 following significant weight changes; and Resident #31's ordered enteral feeding (a feeding tube) water flushes were not provided as ordered. Findings include: The facility policy, Nutrition Assessment, revised 3/17/2023, documented a full nutrition assessment would be completed on each resident after admission and no less than every three months thereafter to assess and evaluate the need for nutrition care according to each person's individual medical condition, needs, desires, and rights. The registered dietitian would complete or cosign initial nutritional assessments, annual nutritional assessments, and significant change assessments. All pertinent information and the rationale for the nutritional plan of care would be evaluated/summarized. The facility policy Gastrostomy Tube Feeding, revised 12/2019, documented the flow rate on the feeding pump would be adjusted according to the physician's order. The procedure documented review physician order for feeding and flushing. 1) Resident #6 had diagnoses including hypertension (high blood pressure), congestive heart failure (insufficient pumping), and adult failure to thrive (overall physical decline). The 9/27/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, did not reject care, required setup or clean up assistance with eating, weighed 209 pounds, had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, was not on a physician-prescribed weight-loss regimen, and received a mechanically altered diet. The Comprehensive Care Plan documented: - 12/27/2023 the resident required supervision at meals. - 1/5/2024 the resident had a nutritional problem related to a history of intakes at meals of less than 75% and a diagnosis of failure to thrive. Interventions included regular diet with thin liquids, monitor intakes and record at each meal, provide supplements as ordered, and weigh per policy. The resident's weight record documented: - on 6/28/2024 238.1 pounds. - on 7/25/2024 209 pounds (12.1% weight loss in 1 month) The was no documented evidence the resident's nutritional needs were re-assessed after the significant weight loss of 29.1 pounds/ 12.1% in 1 month. There was no documented evidence the resident was weighed in 8/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/2/2024 Nurse Practitioner #22 progress note documented the resident was seen for a 60 day follow up visit. The resident received 2 milligrams of bumetanide (diuretic) one time daily for heart failure and had edema (fluid retention). There was no documentation of the resident's weight loss. The resident's weight record documented they weighed 209 pounds on 9/7/2024. The 9/17/2024 Nurse Practitioner #24 progress note documented the resident's body mass index was 31.77 (obese) and their last weight was obtained on 9/7/2024. No edema was noted. The resident had protein calorie malnutrition as noted by a weight loss greater than 7.5% over the past 3 months with a documented weight loss from 238.1 pounds on 6/28/2024 to 209 pounds on 9/7/2024. The resident was to continue a mechanically soft diet, protein supplements, and would continue to be followed by dietary staff. Intakes were to be monitored at every meal and if weight loss continued both dental and speech evaluations would be considered. The 9/27/2024 Nurse Practitioner #24 progress note documented the resident had a 30-pound weight loss since 7/25/2024. Recent laboratory values were reviewed, the resident had no edema present on exam, and they would attempt to decrease 2 milligrams of Bumetanide (diuretic) one time daily to 1 milligram once daily. The 9/27/2024 physician order documented to provide 0.5 tablet of 2 milligrams of Bumetanide (diuretic) one time daily for heart failure. The 9/29/2024 physician orders documented weekly weights on Mondays and was discontinued on Monday 9/30/2024. The 9/29/2024 Diet Technician #29 Quarterly Nutrition Assessment documented the resident received a regular diet, mechanically soft with finely chopped fruit and vegetables, and thin liquids. Supplements included 6 ounces of fortified cereal at breakfast, 4 ounces of ice cream at lunch and dinner, and 30 milliliters of liquid protein once daily. Their weight was 209 pounds, a 34-pound decrease/ 14% loss at 6 months. The resident had no documented edema (fluid retention), their estimated nutritional needs were based on their actual body weight of 209 pounds and were 1880 calories, 76 - 95 grams protein, and 2375 - 2700 milliliters of fluids. The resident would be placed on weekly weights related to significant weight decrease. The resident's weight record documented they weighed 240.4 pounds on 10/1/2024 (a 15% weight increase in one month). The 10/2/2024 Comprehensive Care Plan documented the resident had a potential for fluid deficit/dehydration related to diuretic (water pill) usage. Interventions included to provide medications as ordered and monitor/document side effects. The resident's weight record documented they weighed 240.4 pounds on 10/2/2024, 10/3/2024, and 10/4/2024. On 10/6/2024 Diet Technician #29 documented they were aware of several re-weights documenting weight of 240.4 pounds and they were going to strike out inaccurate recorded weight of 209 pounds on 7/25/2024 and 9/7/2024. There was no documented evidence the resident's nutritional needs were reassessed after a 31.4 pound/ 13% gain after their 9/27/2024 nutrition assessment was completed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/7/2024 the resident's record documented they weighed 233.7 pounds. There was no documented evidence the resident had a re-weight obtained after a weight loss of 6.7 pounds in 3 days. The 10/12/2024 Medical Director progress note documented they saw the resident for a 60 day follow up. The resident received 1 milligram of Bumex (diuretic) once daily, had no edema (fluid retention), weighed 234 pounds, their weight was stable, and the resident requested their diet order be upgraded to a regular diet. On 10/14/2024 the resident's record documented they weighed 204.4 pounds. There was no documented evidence the resident was re-weighed, or their nutritional needs were re-assessed after a documented weight loss of 29.7 pound/ 12.7% weight loss in 2 weeks. The 10/16/2024 Nurse Practitioner #22 progress note documented the resident received 1 milligram of Bumex (diuretic) once daily, had no edema (fluid retention), and weighed 234 pounds. The note did not address the residents weight loss of 29.7 pound/ 12.7% weight loss in 2 weeks. The 10/16/2024 physician order documented the resident was to consume all meals in the dining room for monitoring. The 10/27/2024 Diet Technician #29 progress note documented the resident was re-weighed on 10/24/2024, 10 days after the 10/14/2024 recorded weight of 204.4 pounds. The resident had a documented weight loss of 29.7 pound/ 12.7% weight loss. The resident weighed 204.4 pounds, had a significant weight loss of 12. 5% at 1 month. The resident continued weekly weights. Medical notes documented edema on 10/3/2024, but the resident currently had no noted edema. Weight loss was likely related to fluid fluctuations related to edema. The resident had potential for weight fluctuations related to fluid status changes. There was no documented evidence the resident's nutritional needs were re-assessed. The 12/3/2024 Medical Director progress note documented the resident weighed 206 pounds, had no edema (fluid retention), and was down 40 pounds in the last year. This was likely related to Bumex (diuretic). The resident appeared nutritionally sound. The 1/2/2025 Registered Dietitian #10 Annual Nutritional Assessment documented the resident was on a regular diet with thin liquids. Their documented weight on 12/30/2024 was 199.8 pounds, they were 118% of their recommended weight range, their weight ranged from 200-204 pounds over the past 3 months, they were down 38.3 pounds/16.1% over the past six months, there were some weights struck out in error, and the weight loss rationale was unknown. The resident had edema at times, and currently had no edema. The resident continued weekly weights. Intakes were adequate to meet their estimated needs, and they would discontinue the liquid protein supplement. During an observation on 2/3/2025 at 1:05 PM, the resident was in the main dining room. Their plate included beef stroganoff, carrots, and noodles, a slice of cake, and 2 cups of juice. At 1:42 PM, the resident consumed 100% of their cake and 100% of their juice, and 0-25% of the beef stroganoff, noodles, and carrots. No staff encouragement was observed. During an interview and observation on 2/5/2025 at 3:16 PM, the resident stated they were hungry and did not eat lunch because they thought they slept through the meal. At 3:18 PM, the resident turned on their call bell and an unidentified staff responded. The resident stated they were hungry. At 3:22 PM the unidentified staff brought the resident their meal tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/6/2025 at 8:53 AM, an unidentified staff asked the resident if they wanted to go to the dining room and the resident replied no and they just wanted cranberry juice. At 8:59 AM, Nurse Aide in Training #44 brought the resident their cranberry juice and told the resident if they were going to eat, they needed to eat in the dining room. The resident stated they just wanted their juice. At 9:16 AM, an unidentified staff attempted to bring the resident out into the hallway to eat and they refused and wanted to return to their room. At 9:30 AM, the resident was observed in the dining room eating bacon and eggs. During an interview on 2/7/2025 at 2:45 PM Registered Nurse Unit Manager #28 stated all residents should be weighed the same way, either standing or sitting. The dietitian or diet technician let staff know if a resident needed to have a re-weight obtained. Staff should obtain the re-weight within 24 hours. They stated Resident #6 had a poor appetite and their diet was upgraded to regular consistency to help improve with intakes. They were unsure why the weights had been struck from the record and thought the weight changes could be related to staff not taking the resident's wheelchair weight into consideration. During a telephone interview on 2/10/2025 at 10:07 AM Diet Technician #29 stated the weight lists were sent out every Sunday and Wednesday. The nurses entered the resident's weights into the computer and the computer generated a note if the resident had a significant weight change. If a resident had a significant weight change or a weight was missing, they sent an email to the Nurse Manager to obtain a re-weight. Resident #6 weighed 238.1 pounds in July 2024 and weighed 209 pounds in September 2024. In October 2024 their weight was between 233- 240 pounds. They stated medical saw the resident and noted edema and diuretic usage, and a nutrition note was completed. They did not believe the resident weighed 209 pounds in September 2024 and spoke to the Nurse Manager about it. The resident's intakes were documented as stable. They stated they did not re-assess the resident's needs after they had a significant weight gain in October 2024, and it was important to assess the resident nutritional needs to ensure optimal nutritional status. During an interview on 2/10/2025 at 11:31 AM Registered Dietitian #10 stated Diet Technician #29 followed the resident's weights and did quarterly assessments. They stated they saw the residents on an annual basis and with a significant change. If a resident had a significant weight change the diet technician should let them know and Diet Technician #29 did not discuss Resident #6's weight changes with them. They thought Diet Technician #29 struck out the recorded weight of 209 pounds because it was inaccurate and did not see the medical note attributing the weight loss to the usage of diuretics. The resident's chart did not document they were reviewed for their significant weight changes. It was difficult to follow weight trends if there were missing weights. 2) Resident #31 had a diagnosis of intracerebral hemorrhage (bleeding in the brain) and dysphagia (difficulty swallowing). The11/21/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for most activities of daily living, did not have a swallowing disorder, had a feeding tube, and had an average daily fluid intake of 501 cubic centimeters or more. The Comprehensive Care Plan revised 8/25/2023 documented the need for a feeding tube related to dysphagia and an activities of daily living self-care performance deficit. Interventions included assistance with tube feeding and water flushes. The Comprehensive Care Plan revised 8/30/2023 documented the resident had the potential for dehydration. Interventions included monitor and report any signs of dehydration and monitor lab work as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders documented: - 8/24/2023 the resident was to have nothing by mouth. - 2/28/2024 full strength Glucerna 1.2 (tube feeding formula) at 60 cubic centimeters per hour for 24 hours the resident was to receive 30 milliliters of water every hour via auto flush via the feeding tube (24 hours/day). The 11/26/2024 at 2:23 PM Registered Dietitian #10 quarterly nutritional assessment documented the resident was to receive 30 milliliters of water every hour and their estimated fluid needs were 1925-2310 milliliters a day. The following observations were made of the resident's water flush settings on their feeding pump: -on 2/3/2025 at 10:36 AM 30 milliliters every 4 hours. -on 2/5/2025 at 11:24 AM 30 milliliters every 2 hours. -on 2/6/2025 at 8:30 AM 30 milliliters every 4 hours. -on 2/6/2025 at 2:13 PM 30 milliliters every 4 hours. The February 2025 medication administration record documented the resident received 30 milliliters of water flush every hour via auto flush every shift from 2/3/2025-2/6/2025. During an observation on 2/6/2025 at 8:30 AM, Licensed Practical Nurse #1 entered Resident #31's room, and placed the feeding tube pump on hold while they administered the resident's medications. Licensed Practical Nurse #1 restarted the pump. The pump was set at 30 milliliters water flush every 4 hours. During an interview on 2/5/2025 at 12:13 PM, Licensed Practical Nurse Manager #15 stated the resident was receiving 30 milliliters of water flushes every 2 hours via the pump. During an interview and observation on 2/6/2025 at 2:15 PM, Licensed Practical Nurse Manager #15 stated the fluid recommendations were made by the registered dietitian and required a physician order. They expected nurses to check the pump settings were correct when signing the medication administration record. Resident #31's water flush was set for 30 milliliters every 4 hours but should have been set to 30 milliliters every 2 hours. After changing the pump to 30 milliliters every 2 hours, they checked the order and stated the order was 30 milliliters every 1 hour and was effective on 2/28/2024. The nurses were signing the resident received 30 milliliters of water every one hour when they did not. It was important the resident's water flush settings were correct otherwise they could become dehydrated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/10/2025 at 11:03 AM, Registered Dietitian #10 stated they were responsible for determining a resident's feeding and fluid needs. They made that determination based on variables such as height, weight, and laboratory values. Their recommendations required a physician order, and it was the responsibility of nursing to make sure the resident received what was recommended. Resident #31 had been stable and had no issues with weight loss or dehydration. The resident depended solely on the gastrostomy tube for hydration and nutrition and should have been receiving 30 milliliters of water every hour. They were at risk for dehydration due to their dependence on staff, and staff should always ensure the resident was getting the necessary fluids. The resident's fluid needs were 1925-2310 milliliters a day. If the resident's pump had been set at 30 milliliters every 4 hours that would have decreased their 24-hour fluid intake and the resident would not meet their hydration needs. Inadequate fluid could cause overall health decline, constipation, and dehydration. 10NYCRR415.12(i)(1) 48052

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 35045 Based on observations and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not post daily current resident census and the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift in a prominent location readily accessible to residents and visitors for 6 of 6 days reviewed. Specifically, daily nurse staffing was not posted daily at the beginning of the shift as required on 2/3/2025, 2/4/2025, 2/5/2025, 2/6/2025, 2/7/2025 and 2/10/2025 as required. Findings include: The facility policy, Staffing, effective 4/1/2022, documented staffing was evaluated at the beginning of the shift and adjusted as needed by the Nurse Manager/designee. Staffing analysts were available and supported the designee during hours they were available and included providing timely accurate data to the staffing office when needs changed, and daily full-time equivalent was posted in the glass display case by the night supervisor with updates made by the shift supervisors as needed. The daily nurse staffing and resident census information was not posted in the main lobby, on the main entrance doors, or on the reception desk during the following observations: - on 2/3/2025 at 9:15 AM. - on 2/4/2025 at 8:00 AM. - on 2/5/2025 at 8:31 AM. - on 2/6/2025 at 7:40 AM. - on 2/7/2024 at 8:20 AM. - on 2/10/2025 at 8:15 AM. During an interview on 2/10/2025 at 9:25 AM, the Administrator stated staffing, and the resident census should be posted in the front lobby. They stated things came up missing from the front desk. During an interview on 2/10/2025 at 10:02 AM, Human Resources/Staffing Scheduler #25 stated they were aware staffing should be posted. They observed the front desk and stated posted staffing was not where it was supposed to be. They stated it should have been posted there, and it was usually in a clear frame on the receptionist desk. They did not what happened to it. They stated it was important to have daily nurse staffing posted to know what the facility census was and to ensure a registered nurse was in the building. 10 NYCRR 415.13

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50561 Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025 - 2/11/2025, the facility did not ensure a system of records and accounts of all controlled drugs was maintained for 1 of 3 nursing units (Unit 3) reviewed. Specifically, a controlled substance reconciliation (a system of recordkeeping that ensures an accurate inventory by accounting for controlled medications that were received, dispensed, and administered) was not performed between the oncoming and outgoing nurse; the narcotic count log form was completed and signed without a count being performed; narcotic keys were not transferred between nurses in a secured manner; and Resident #65's Controlled Substance Record was not accurately reconciled after the medication was administered to the resident. Findings include: The facility policy, Storage and Maintenance of Medications, revised 5/2019, documented medications and biologicals were stored safely, securely, and properly and the medication supply was accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The facility policy, Management of Controlled Medications, dated 11/2019 documented the facility ensured all controlled medications were maintained in a manner to guarantee accountability, security, and accessibility; at every change of shift, the outgoing and incoming nurses, together, would do a physical count of the remaining medication, assuring that the amount present matched the amount documented on the Resident Narcotic Record; and proper storage of controlled drugs were kept in a double-locked medication area and the nurse would carry the keys on their person at all times. The 1/30/2025 physician order for Resident #65 documented Klonopin 0.5 milligrams (clonazepam; a narcotic anti-anxiety medication) twice a day. The February 2025 Medication Administration Record documented Resident #65 was administered one clonazepam 0.5 milligram tablet on 2/3/2025 at 8:00 PM by Licensed Practical Nurse #43. During an observation on 2/4/2025 at 1:29 PM, the narcotic compartment of the Unit 3 North medication cart contained fifty-two (52) clonazepam 0.5 milligram tablets labeled with Resident #65's name. Resident #65's Controlled Substance Record form documented there should have been fifty-three (53) clonazepam 0.5 milligram tablets. During an interview on 2/4/2025 at 1:29 PM, Licensed Practical Nurse #13 stated the reason for the discrepancy between the number of pills in the medication pack and what was listed on the Controlled Substance Record form was due to a nurse not signing out the clonazepam the night before on 2/3/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Controlled Substances Shift to Shift Count Log documented the oncoming medication nurse, Licensed Practical Nurse #1, and the outgoing medication nurse, Licensed Practical Nurse #2 signed the count had been done on 2/4/2025 at 6:00 AM for 8 different narcotic prescriptions, including Resident #65's clonazepam which documented fifty-four (54) tablets were present. During an interview on 2/4/2025 at 1:35 PM, Licensed Practical Nurse #1 stated all narcotics had to be counted off with another nurse before transferring narcotic keys to each other. They stated they came in at 6:00 AM that day to relieve Licensed Practical Nurse #2. They did not count narcotics with each other. Instead, Licensed Practical Nurse #2 handed them the narcotic keys and left because their ride was waiting. Before leaving, Licensed Practical Nurse #2 filled out the pill count on the Controlled Substances Shift to Shift Count Log form and signed it. Licensed Practical Nurse #1 stated they cosigned the log form after Licensed Practical Nurse #2 left for the day. They not noticed Resident #65's clonazepam count was incorrect because they did not look at their Controlled Substance Record to verify. They stated there were times on the night shift when a supervisor also worked as a floor nurse and had narcotic keys for the Third floor. The supervisor left those keys on the Second floor so when the day shift nurses arrived, they could pick up the keys and start the medication pass. A count with the supervisor was done later when the supervisor came to the unit. Counting narcotics was important because someone could lose their license, medications could go missing, and residents may not have the medications they needed. During an interview on 2/6/2025 at 2:23 PM, Licensed Practical Nurse Unit Manager #15 stated anytime there was a transfer of narcotic keys a count should be performed, but did not always happen. Currently, because there was not a full time 10:00 PM - 6:00 AM Nurse Supervisor, floor nurses were being utilized as both the house supervisor and a unit nurse. At 6:00 AM, the nurse should stay until they counted narcotics with the oncoming day nurse. If there was not a nurse to relieve them at 6:00 AM some nurses left the narcotic keys on the Second floor nursing station desk for the day shift nurse to pick up when they arrived. There was always a nurse in the building, but some were not agreeable to counting off narcotics on a floor they were not assigned to. It was not uncommon for them to get calls at 6:00 AM from one of the nurses asking them to come and count off the narcotics so they could leave. They spoke to the Director of Nursing twice within the last couple of weeks to address the issue. They stated the Director of Nursing was working on holding those nurses accountable and told them they could do the same to address the issue. Performing a count before transferring keys was important because the count could have been incorrect and could have fallen on whomever accepted those keys. If someone did not count, they should not sign the log sheets indicating that they had. During an interview on 2/7/2025 at 2:18 PM, Licensed Practical Nurse #14 stated they worked the day shift on Second floor. Many nurses came in whenever they wanted rather than coming in right at the change of shift. If the outgoing night nurse did not want to wait or could not wait for their replacement, they brought the narcotic keys to the Second floor nursing station, placed them behind the computer, gave a brief resident report to the Second floor day nurse and left. The keys were not secured and were accessible to anyone who wanted them. That practice had been going on for quite a while. They were not asked by other floor nurses to count off with them but would have if they had been asked. Narcotic keys should not be left unattended as narcotics could go missing and it could be considered abandonment. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/10/2025 at 11:28 AM, the Corporate Regional Director of Nursing stated anytime there was an exchange of narcotic keys there had to be a count and verification the count was correct. That was important to ensure that all narcotics were accounted for. If a nurse needed to leave and did not have someone to relieve them, they should call the supervisor and could not just leave. They were recently made aware of an issue of a nurse leaving without counting. That nurse left the narcotic keys on the Supervisor's desk on the Second floor which was kept locked if no one was in there. They spoke with that nurse, verified the count was correct, and was not aware of any ongoing issues. There were no problems with missing keys or with diversion. Nurses should not fill out the narcotic count sheets and sign it without counting and no one should be leaving without counting. During a follow up interview on 2/10/2025 at 3:38 PM, Licensed Practical Nurse Unit Manager #15 stated the Supervisor used the Second floor Nurse Manager's office. The key to that office was not on the floor nurses' narcotic key rings and therefore they would not have access to that office unless someone left it open. Their experience was the keys were always left at the nursing station not in the Second floor Nurse Manager's office. 10NYCRR 415.18

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33421 Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional standards for 3 of 4 medication carts (4th floor North, 4th floor South, and 3rd floor North medication carts). Specifically, the 4th floor medication carts (North and South carts) and the 3rd floor North medication cart had expired stock medications and insulin. Findings include: The facility policy, Storage and Maintenance of Medications, dated 10/2020 documented medications with shortened expiration dates, to include insulin and ophthalmic drops, must be dated when opened. Medications must be checked regularly for expiration dates and deterioration. Expired medications were to be removed from use. The overnight nurse was responsible for checking the medication carts, medication cabinets, and the refrigerator weekly for expired medications. During a medication storage observation on 2/4/2025 at 1:04 PM with Licensed Practical Nurse #13, the 3rd floor North medication cart's top drawer had the following medications: - Resident #17 had a Anoro Ellipta inhaler (used to treat lung disease) with no opened date and the medication was discontinued on 1/7/2025. - Resident # 86 had atropine eye drops with no opened date and the medication was discontinued on 12/24/2024. - Resident # 31 had tobramycin (antibiotic) 0.3% eye drops discontinued on 1/1/2025. - Resident # 11 had a Humalog quick insulin pen with no pharmacy label and no opened date and only the resident's name was written on the pen cap with a sharpie. - an unlabeled 30 milliliter plastic medicine cup was filled to the top with round white round tablets. Licensed Practical Nurse #13 stated they were acetaminophen (pain reliever) 500 milligram tablets. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 1:17 PM, Licensed Practical Nurse #13 stated each medication should be labeled with the opened date, as that was considered the expiration date. Insulins expired within 28 to 60 days depending on the type of insulin. Opened expiration dates for eye drops, inhalers, and nose sprays varied based on the medication. An expired medication may not have the desired effect. By writing the opened date on the medication, it would alert the nurse if the medication was past the expiration date and should not be given. They stated they administered Resident #17 their Anoro Ellipta inhaler and Resident #11 their Humalog insulin that morning. During an additional interview at 1:34 PM, Licensed Practical Nurse #13 stated the acetaminophen was in the clear medicine cup when they came in that morning. The facility only purchased big bottles of the acetaminophen and was split between the 2 medication carts. One cart kept the large bottle and the other put them in a medicine cup for easier accessibility. The nurse stated they did not administer any medicine from the medicine cup that shift. During a medication storage observation and interview with Licensed Practical Nurse #26 on 2/4/2025 at 1:48 PM, the 4th floor North top drawer of the medication cart contained the following medications: - an opened bottle of Geri Care mucus relief with a manufacturer's expiration date of 9/2024 and a handwritten opened date of 11/2024 on the side of the bottle. - an opened bottle of aspirin 81 milligrams with no manufacturer's expiration date or opened date. Licensed Practical Nurse #26 stated they were not sure who was assigned to check the medications for expired dates, but each nurse should check them prior to administering a medication to a resident. The nurses were able to get new bottles of stock medication from the medication room or central supply if needed. During a medication storage observation and interview with Licensed Practical Nurse #27 on 2/4/2025 at 2:09 PM, the 4th floor South top drawer of the medication cart had an opened bottle of aspirin 81 milligrams that did not contain a manufacturer's expiration date and had a handwritten opened date of 1/17/2025 on the side of the bottle. Licensed Practical Nurse #27 stated the medication was considered expired since there was no readable expiration date on it. Each nurse was supposed to check expiration dates of each medication prior to giving it to a resident. An expired medication may not be effective. They stated Resident #77 received the medication that morning and was not sure why the expiration date was not checked. During an interview on 2/4/2025 at 2:18 PM, Registered Nurse Manager #28 stated each nurse was supposed to check each medication's expiration date prior to giving it to the resident. The Geri care mucus relief should never have been open as was expired prior to the opening date. They were not sure who was responsible for checking medication carts and rooms. 10NYCRR 415.18(d) 50561

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Utica Rehabilitation & Nursing Center	2535 Genesee Street Utica, NY 13501

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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 0800

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

49448

Based on observation, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did provide each resident with a nourishing, well-balanced diet that considered the preferences of each resident for 1 of 2 residents (Resident #24) reviewed. Specifically, Resident #24 was not provided their preferred meal choices.

Findings include:

The facility policy, Obtaining/Recording Food Preferences, effective 4/5/2020, documented the facility identified and recorded each resident's food/beverage preferences to coordinate meal preparation/service to promote adequate nutrition. The food service director, diet technician, or registered dietitian would complete a dietary interview with the resident and complete sections on likes and dislikes and information would be entered into the nutrition management system for incorporation into meal tickets. During the interview residents would be provided with a copy of the cycle menu and the alternate menu.

The facility policy, Substitutions, dated 1/2022, documented all substitutions were noted on the menu and filed in accordance with established dietary policies and residents' likes and dislikes would be considered when making substitutions.

Resident #24 had diagnoses of diabetes and chronic obstructive pulmonary disease (lung disease). The 1/23/2025 Minimum Data Set assessment documented the resident had intact cognition, required set up assistance for eating, and did not receive a therapeutic diet.

The Comprehensive Care Plan documented:

- revised 11/15/2022 the resident had diabetes and was non-complaint with their diet and frequently ordered out. Interventions included offer substitutions for foods not eaten. had a nutritional problem or potential nutritional problem related to diabetes. Interventions included to provide and serve supplements as ordered.

- revised 10/27/2024 the resident had nutritional problems related to therapeutic diet, history of non-compliance, and ordered take-out food frequently. Interventions included encourage diet compliance, no added salt, low concentrated sweets, regular texture diet, meals in room, monitor intake, and provide and serve supplements as ordered.

The 1/21/2025 at 7:08 PM Dietetic Technician #29 Quarterly Nutritional Assessment documented the resident was to receive 4 fried eggs and 4 ounces of yogurt at breakfast. The resident had weight fluctuations due to fluid changes.

During an observation and interview with Resident #24 on 2/6/2025 at 9:44 AM, the resident's breakfast meal ticket documented 4 fried eggs, yogurt, and cold cereal. The resident's tray had one fried egg, and no yogurt or cold cereal. Resident #24 stated if they received the yogurt and cereal they would have eaten it.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/6/2025 at 9:48 AM, Certified Nurse Aide #7 stated the dietary department put all the food on the trays and the aides checked for accuracy and served the trays to the resident. Sometimes it was a mixture of both departments placing food items on the tray. They delivered Resident #24's breakfast that day and did not notice the cereal and yogurt were missing. The resident should have received four fried eggs but did not. If the items were short the resident would not receive the calories they needed. During an interview on 2/6/2025 at 9:55 AM, Dietary Aide #39 stated they thought they gave Resident #24 four fried eggs but may have confused them with another resident. During an interview on 2/7/2025 at 1:09 PM, Resident #24 stated staff did not ask them what they wanted to drink, did not provide them a menu, and did not tell them about food alternatives. They asked for soup and salads, and they would not get them, or they would receive a salad that only had lettuce. They felt it was important to have the option of choosing their meals. During an interview on 2/7/2025 at 1:20 PM Certified Nurse Aide #12 stated residents often asked what was being served for that day and they would have to ask dietary staff because menus were not posted anywhere. Activities used to hand out menus, but they did not think they were doing that anymore. There was always an alternate such as hot dogs or hamburgers and they usually ran out of the alternatives. They had never seen an alternate list but knew there was always a soup and a sandwich option too. During an interview on 2/7/2025 at 1:28 PM, Unit Manager #15 stated they used to have the menu and substitutes posted on a bulletin board in the dining room, but they were removed when the remodeling started and were never put back up. Residents asked them every day what was being served for each meal. The dietary ticket was based on dietary preferences and Resident #24 should get what was on their ticket. During an interview on 2/10/2025 at 10:47 AM, Dietetic Technician #29 stated menus were distributed to residents on admission. Menus and a list of alternatives were previously posted on the units, but because of the remodeling they were taken down and never went back up. Residents could ask for a menu or call downstairs to find out what was on the menu. It was important for residents to know what was on the menu so they could ask for something different. Resident #24 ordered out a lot and asked for extra food. They usually wanted something different than what was on their ticket. The items listed on their ticket should be provided. 10NYCRR 415.14 50561

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 49448 Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 2 of 3 unit kitchenettes (Units 3 and 4) and the main kitchen. Specifically, there were unclean surfaces in the Units 3 and 4 floor kitchenettes and main kitchen; moldy bread in the 4th floor kitchenette; and inaccurate thermometers in the walk-in cooler off the kitchen and the economy refrigerator in the main kitchen. Findings include: The undated facility policy, Cleaning and Sanitizing of Small Equipment, documented small equipment such as blender bases, vegetable choppers, and grinder slicers were cleaned and sanitized to prevent the spread of harmful bacteria to residents and staff. The undated facility policy, Food and Supply Storage documented all food and supply items were held and stored safely and securely and maintained quality and protected against contamination, spoilage, and theft. All storage areas were kept clean and in good working condition at all times. The undated facility policy, Procedure-Freezer and Refrigeration, documented coolers and freezers were thermostatically controlled and monitored for proper temperature control by appropriate properly working thermometers. Refrigerator temperatures were maintained between 33 -41 degrees Fahrenheit. Freezers were maintained at 0 degrees Fahrenheit or below. Temperatures of all coolers and freezers were documented twice daily on the appropriate logs. During operating hours, the temperatures were observed throughout the day. Any deviation outside the appropriate temperature range was immediately reported to the supervisor or director. MAIN KITCHEN The following observations were made in the main kitchen on 2/3/2025: - At 9:21 AM, there were multiple sugar packets, food scraps, and other debris on the floor in the dry storage room. - At 9:24 AM, there were two cases of frozen vegetables and packaging debris on the freezer floor. The walk-in cooler just outside of the freezer had food debris and packaging debris on the floor. - At 9:26 AM, there was debris and grime, behind, under, and around the ice cream freezer and dried food debris on the slicer. - At 9:28 AM, there was dried debris under and around the kitchen cook line and dried on spills in and under the economy refrigerator at the end of the cook line. The ice machine's scoop was directly on top of the ice inside the machine and there was an empty pitcher on top of the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- At 9:39 AM, the walk-in freezer had food and packaging debris under the shelving. The following observations were made in the main kitchen on 2/4/2025: - At 1:07 PM, there was food debris in the walk-in freezer. - At 1:08 PM, the mop boards were in disrepair along the back wall to the left of the dry storage room. There were dried food spills and debris under the cook line equipment. - At 1:17 PM, the walk-in cooler off the kitchen measured at 38 degrees Fahrenheit and the thermometer in the cooler read 32 degrees Fahrenheit while the exterior thermometer read 20 degrees Fahrenheit. There was food debris and packaging on the floor under the shelving. - At 1:28 PM, the slicer had dried food debris. - At 1:29 PM, there was grease, grime, and food debris behind the coffee maker. - At 1:40 PM, the economy refrigerator contents measured between 43-45 degrees Fahrenheit, and the thermometer read 30 degrees Fahrenheit. KITCHENETTES: The following observation was made in the third-floor kitchenette on 2/4/2025: - At 12:40 PM, there were food spills and debris in the white residential refrigerator. The following observations were made of the fourth-floor kitchenette on 2/4/2025: - At 12:17 PM, there was a small amount of orange colored liquid spilled in the cooler. - At 12:18 PM, there was moldy bread in the cabinet behind the service line. TEMPERATURE LOGS The February 2025 facility temperature logs documented the following out of range temperatures of the small walk-in cooler: -on 2/4/2025 24 degrees Fahrenheit -on 2/5/2025-2/7/2025 32 degrees Fahrenheit -on 2/8/2025 and 2/9/2025 there were no documented temperatures -on 2/10/2025 30 degrees Fahrenheit -on 2/11/2025 32 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/2025 at 1:22 PM, The Food Service Director stated they went by the thermometers on the outside of the cooler. They agreed the thermometers did not match and were not accurate. They should be accurate, but they only looked at them and there were no other checks in place. During a telephone interview on 2/10/2025 at 12:46 PM, the Food Service Director stated the cooks did rounds of the kitchen coolers, units, and storage areas when they came in for the day. The dietary aides were responsible to ensure the kitchenettes were cleaned and mopped after each shift. There should not be moldy bread in the kitchenettes because it could make someone sick. The kitchen was supposed to be cleaned after using equipment or tables. The walk-in cooler floors and floors under and around the equipment were cleaned daily by the dishwasher. The slicer should have been cleaned by the cook after each use. The tiles along the walls, missing mop boards, and missing tiles on the electrical/ janitor's closet were not smooth and therefore not easy to clean. It was important kitchen preparation equipment and service areas were kept clean and easily cleanable for sanitation and prevention of bacteria growth that could make the residents sick. 10NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 33421 Based on observations, record review, and interviews during the recertification survey conducted 2/3/2025-2/11/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 units (Units 2 and 3) observed. Specifically, Units 2 and 3 floors did not have proper signage for transmission based precautions, and personal protective equipment was not readily accessible. Additionally, Licensed Practical Nurse #37 performed gastrostomy tube (feeding tube) care without wearing required personal protective equipment, and Resident#31's suction equipment was not maintained or stored in a sanitary manner. Findings included: The undated facility policy, Standard Precautions for Infection Control, documented gloves were to be worn when touching blood, body fluids, secretions, excretions, and contaminated items. Gowns were worn to protect skin and prevent soiling of clothing during procedures that were likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. The undated facility policy, Contact Precautions for Infection Control, documented all personnel having direct contact with a resident on contact precautions was required to follow all standard and isolation precautions procedures. Contact precautions were used for specific residents known or suspected of having infected or colonized (germs present with no signs or symptoms) microorganisms that could be transmitted during direct care. An appropriate sign would be placed on the door of the resident's room. Gowns and gloves would be worn for potential direct resident contact. The facility policy, Cleaning and Disinfection of Resident Care Items and Equipment, revised 5/2023, documented devices such as respiratory equipment would be free from all microorganisms. The policy did not document how often the equipment should be disinfected or cleaned. The facility policy, Enhanced Barrier Precautions- Multidrug-Resistant Organisms, dated 4/1/2024, documented signage must be posted on the door or wall outside of the resident's room indicating enhanced barrier precautions and required personal protective equipment. A personal protective equipment station would be set up. The station placement should be near or outside the resident's room. Put on gowns and gloves before or upon entry to that room. Position waste receptacle inside the resident room and near the exit for discarding personal protection equipment. 1) Resident #100 had diagnoses including stroke, diabetes, and Parkinson's (a progressive neurological disorder). The 1/1/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, had a feeding tube, and a Stage 2 (partial thickness skin loss) pressure ulcer. The 2/3/2025 physician order documented contact isolation for Extended-spectrum beta-lactamases (antibiotic resistant organism) and Methicillin-resistant Staphylococcus aureus (antibiotic resistant organism). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 2/3/2025 at 10:12 AM, Resident #100's room had no precautionary signs or personal protective equipment on the door/doorway. During an interview on 2/7/2025 at 2:49 PM, the Director of Environmental Services #8 stated they were given a list of residents on contact precautions and enhanced barrier precautions on 2/3/2025 and they ensured the appropriate signs were placed outside the room doors. Any resident on contact/droplet precautions should have a full personal protective equipment station on their door. Anyone on enhanced barrier precautions should have a sign on the door and the equipment should kept in the clean linen room for staff to use. Equipment was also kept in the unit treatment cart. They stated prior to 2/3/2025, they stated their department was only responsible for ensuring the personal protective equipment was supplied to the units. They stated the nursing department performed random audits of the equipment and signage but did not know how often. They did not know why signs were not in place for Resident #100's room on 2/3/2025. During an interview on 2/10/2025 at 9:17 AM, Licensed Practical Nurse Infection Preventionist stated the nurses on the floor were responsible for ensuring the appropriate precautions signs were placed outside each resident's door that was on precautions. The Director of Environmental Services was responsible for putting up the personal protective equipment stations when a work order was submitted by the nurse who entered the physician order for precautions. Enhanced barrier precautions were for any resident with indwelling tubes or treatments. Residents were on contact precautions if they had an active infection. Enhanced barrier precautions and contact precautions meant staff should wear a gown and gloves with direct resident contact and a surgical mask should be worn with droplet precautions. These should be worn to prevent cross contamination of germs. All precautions rooms should have a red biohazard bags for soiled items. The Licensed Practical Nurse Infection Preventionist did not know why the proper signage and equipment were not readily available to staff. During an interview on 2/10/2025 at 9:54 AM, Registered Nurse Manager #28 stated the Unit Managers were responsible for ensuring signage and personal protective equipment stations were up. Environmental services supplied the units with the equipment stations. They did not know why the appropriate signage and stations were not in place on 2/3/2025. They stated if signage was missing, they should call the Infection Preventionist for signs and the Director of Environmental Services for personal protective equipment supplies and stations. Staff were required to wear gowns and gloves to provide direct care for any resident on contact or enhanced barrier precautions. They should also wear a surgical mask for residents on droplet precautions. The purpose of personal protective equipment was to prevent cross contamination of germs. During a wound treatment observation and interview on 2/10/2025 at 1:32 PM, Licensed Practical Nurse #37 went to the clean linen room and there was no personal protective equipment. They then went to the Unit Manager's office for the supplies. They obtained surgical masks from the nursing station and went to Resident #100's room. The door had a contact precautions sign in place, and there was no personal protective equipment station on or near the resident's door. The contact precaution sign documented staff were to wear a gown and gloves when providing care. The nurse put on a gown and gloves, performed the wound treatment, removed the personal protective equipment, and place the items in a regular garbage bag. There were no red biohazard bags available. The nurse stated the required equipment was supposed to be on the door and usually was in the clean linen room. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

2) Resident #31 had a diagnosis of intracerebral hemorrhage (bleeding in the brain) and dysphagia (difficulty swallowing). The 11/21/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for most activities of daily living, and had a feeding tube.

Physician orders documented:

- on 8/24/2023 oral care every shift.

- on 7/25/2024 the resident was on enhanced barrier precautions.

The 7/25/2024 Comprehensive Care Plan documented the resident was on enhanced barrier precautions due to a tube feeding. Interventions included using gown and gloves when performing high contact activities including care of device or any activity with close contact.

During an observation on 2/3/2025 at 10:36 AM, Resident #31 had an enhanced barrier precaution sign outside their door.

The following observations of Resident #31's suction equipment were made on 2/3/2025 at 10:36 AM, 2/4/2025 at 9:56 AM, and 2/5/2025 at 11:24 AM:

-the suction canister, tubing and Yankauer (a type of oral suction catheter) were connected, not dated, and sitting on the resident's nightstand.

-the collection canister contained approximately 200 milliliters of clear, frothy fluid.

-the Yankauer catheter was laying directly on the nightstand and not in a protective sleeve.

During an observation on 2/5/2025 at 12:13 PM, Licensed Practical Nurse Manager #15 entered Resident #31's room to administer 1:00 PM medications. They applied a pair of latex gloves, disconnected the tube feeding, administered medications through the tube, flushed the tube, then reconnected the feeding tube. They performed a dressing change to the resident's gastrostomy tube site. They did not put on a gown prior to performing those activities.

During an interview on 2/5/2025 at 12:26 PM, Licensed Practical Nurse Manager #15 stated residents who received a tube feed had an as needed suction order. If a suction collection canister was dirty or full it should be changed on evenings and the whole machine was washed and set up to dry every Sunday evening. The Yankauer should be left in the packaging sleeve or in a baggie dated and timed in between uses. Resident #31's canister was dirty; the tubing and canister were not dated; and the Yankauer was sitting next to the canister uncovered and undated. If the Yankauer was being set directly on their table it could be exposed to a multitude of organisms and bacteria and could cause illness. The resident was on enhanced barrier precautions because of their tube feeding. The dressing change and medication administration were considered high contact activity, and they should have worn a gown when they performed those activities. That was important to protect both themselves and the resident from exposure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/7/2025 at 2:48 PM, the Licensed Practical Nurse Infection Preventionist stated the suction canister, and tubing should be changed after each use and the Yankauer should be changed daily, dated when opened, placed back in the packaging and remain covered between uses, and should not be sitting on a table unprotected. The suction collection canister should be changed and not sitting for several days with sputum in it. It could harbor germs and bacteria that could then enter the resident and lead to sickness. The resident should be on enhanced barrier precautions for the indwelling tube feed. Changing the gastrostomy dressing and administering medications and feeding via the tube was considered high contact activity. Nurses should not perform those activities without the required personal protective equipment on. That was important because it protected staff and the resident and prevented the introduction of any germs. 10 NYCRR 415.19(a)(b) 50561