STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335471	A. Building B. Wing	02/23/2026

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 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. Based on observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for two (2) of four (4) medications carts (Unit 3 South and Unit 4 North) and one (1) of two (2) medications rooms (Unit 4) reviewed. Specifically, the Unit 3 South medication cart had expired eye drops and nasal spray; the Unit 4 North medication cart had opened unlabeled inhalers, expired or unlabeled eye drops, one insulin pen was missing the pharmacy label, the resident's name, and date opened and one insulin pen was not labeled with an opened date; and the Unit 4 medication room refrigerator was not maintained at an appropriate temperature.Findings included:The facility policy Storage and Maintenance of Medications, revised 05/2019 and effective 10/2020, documented the medication refrigerator must maintain a proper temperature of 36-46 degrees Fahrenheit. Medications with shortened expiration dates, such as insulin injections and ophthalmic drops, were to be dated when opened. The overnight medication nurse was responsible for checking the medication cabinet, carts, and refrigerator for expired medications every week.The facility policy Insulin Storage, effective 02/09/2024, documented upon first use of an insulin vial or pen it was labeled with the date opened, beyond-used date, and the nurse's initials. If the beyond date was not written, the product was to be discarded. Medication refrigerator temperatures were also logged daily, and any temperature outside 36-46 degrees Fahrenheit was reported immediately to the nursing supervisor and pharmacy.The facility reference guide Medication Storage and Expiration Quick Reference, dated 2016, documented Lantus (long-acting insulin) was to be discarded 28 days after opening. During an observation and interview with Licensed Practical Nurse #8 on 02/18/2026 at 8:45 AM, the medication refrigerator on Unit 4 had a temperature of 56 degrees Fahrenheit and 68 degrees Fahrenheit read from the facility thermometer inside the refrigerator by Licensed Practical Nurse #8. They stated temperatures were checked and documented by the night nurses. They were not sure what the temperature was supposed to be as they did not check it.The 02/2026 Unit 4 refrigerator temperature log documented on 02/2027 the refrigerator temperature was not greater than 40 degrees Fahrenheit during the month, and on 02/18/2026 the refrigerator temperature was 40 degrees Fahrenheit.During an observation and interview with Licensed Practical Nurse #8 on 02/18/2026 at 8:51 AM, the top drawer of Unit 4 North medication cart had Trelegy Ellipta (an inhaler used to treat asthma) that was not labeled with an open date. The bag the inhaler was kept in, documented a prescription date of 09/01/2025 and to discard after six weeks. Licensed Practical Nurse #8 confirmed there was no open date listed on the inhaler and there should have been. The nurse who opened the medication was responsible for putting the open date on. They were not sure when inhalers expired or why the medication did not have an open date. Additionally, there were two Lantus pens (long-acting insulin), one pen had no pharmacy label or label of any kind with the resident's name and when the pen was opened; and the second pen had a pharmacy label but was missing the opened date. Licensed Practical Nurse #8 stated they were unsure why there was no pharmacy label on one of the pens. They stated it was not a big deal that the Lantus pen did not have a resident name as there was only one resident it would have belonged (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to. Checking expiration dates was the responsibility of everyone. The third drawer had two Artificial Tears (eye drops for lubrication) and Visine (eye drops to reduce redness) that were opened on 11/11/25. During an observation and interview with Licensed Practical Nurse #8 on 02/18/2026 at 12:12 PM, the Unit 4 medication refrigerator had a temperature of 56 degrees Fahrenheit. Licensed Practical Nurse #8 stated they replaced the thermometer, and it read 44 degrees Fahrenheit.During an observation and interview with Licensed Practical Nurse #3 on 02/19/2026 at 3:39 PM, the medication refrigerator was 60.3 degrees Fahrenheit. Licensed Practical Nurse #3 stated the temperature on the facility thermometer read 38.5 degrees Fahrenheit.During an observation and interview with Maintenance Technician #11 on 02/19/2026 at 3:46 PM, the refrigerator temperature was 58 degrees Fahrenheit after it was in the refrigerator for five minutes. Maintenance Technician #11 confirmed the temperature and placed two facility thermometers in the refrigerator.During an observation and interview with Licensed Practical Nurse #3, on 02/19/2026 at 4:00 PM, they stated the two thermometers that were placed in the refrigerator by maintenance both read 54 degrees Fahrenheit.During an interview on 02/19/2026 at 4:09 PM Registered Nurse Unit Manager #10 stated the overnight shift checked the medication carts and discarded expired medications. Insulin, inhalers and eye drops needed to be labeled when opened. They expected staff to discard open medication that was not labeled with an opened date. An insulin pen without a pharmacy label should be discarded and not used. There was no way to ensure the pen was not used by someone else. The medication refrigerator temperature was checked by overnight nurses and was 36-46 degrees Fahrenheit.During an observation and interview with Licensed Practical Nurse #12 on 02/19/2026 at 3:17 PM, the top drawer of the Unit 3 medication cart had Refresh ophthalmic solution (eye drops) with an opened date of 11/04/2025. Licensed Practical Nurse #12 stated that the eye drops were expired and should have been thrown out. The third drawer in the medication cart had Fluticasone nasal spray with an open date of 12/18/2025. Licensed Practical Nurse #12 stated that they were unsure when it expired after it was opened, but it was probably expired and needed to be discarded. They stated that they tried to look through the medication cart every day and discard expired medication. Residents should not receive medication that was expired.During an interview on 02/23/2026 at 10:10 AM Registered Nurse Unit Manager #13 stated the night shift checked the medication carts for expired medications and they did monthly audits. They were not sure how long after eye drops or nasal sprays were opened that they expired. They needed to look at the policy, but policies were not readily assessable and had to call the Assistant Director of Nursing or the Director of Nursing to get the answer. Nasal spray that was opened on 12/18/2026 was probably expired and needed to be discarded, also Refresh eye drops that were opened on 11/04/2025 were expired and should not have been in the medication cart. They were unsure how these medications were missed during their monthly audits or the nightly checks by the night shift nurses. 10 New York Codes, Rules and Regulations 415.18(d)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and interviews during the recertification survey (complaint #2738777) the facility failed to honor advance directive wishes for one (1) of one (1) resident (Resident #14) reviewed. Specifically, Resident #14 had a Medical Order for Life-Sustaining Treatment documenting do not resuscitate (do not attempt resuscitation, allow natural death). Cardiopulmonary resuscitation (chest compressions) was initiated, and an automated external defibrillator (a device that analyzes the heart's rhythm and, if necessary, delivers an electrical shock, to help the heart re-establish an effective rhythm) was used when Resident #14 did not have a pulse. Findings included: The facility policy Advance Directives, revised 07/2019, documented Do Not Resuscitate as indicated under New York State law instructs medical professionals not to perform cardiopulmonary resuscitation in cases of cardiac arrest. If a resident was found to be in cardiac arrest (without pulse and respirations), cardiopulmonary resuscitation would not be initiated.Resident #14 had diagnoses including peripheral vascular disease (poor circulation) and atherosclerosis (plaque buildup in artery walls). The 01/08/2026 Minimum Data Set assessment documented the resident had intact cognition and their advance directives were do not resuscitate and do not intubate.The Medical Orders for Life Sustaining Treatment form, signed by Resident #14 and a medical provider on 05/17/2022 documented Do Not Attempt Resuscitation (allow natural death). The form was last reviewed by the medical provider on 11/04/2025 with no changes made. The 05/19/2022 medical order by Family Nurse Practitioner #6 documented do not resuscitate.The 01/02/2026 comprehensive care plan documented do not resuscitate status and the resident's wishes would be honored. Interventions were to verify code status with physician orders, health care proxy was in place, and the Medical Orders for Life Sustaining Treatment form was in place.The 02/27/2026 facility investigative summary documented:- At approximately 12:12 PM on 02/07/2026, Resident #14 was noted by Licensed Practical Nurse #3, to have experienced an acute change in condition in the dining room on the third floor.- Licensed Practical Nurse #3 found the resident sitting upright in their chair, able to move air and take a sip of their drink without distress. They were unable to visualize any food or foreign body obstruction.- Licensed Practical Nurse #3 attempted to perform the Heimlich (abdominal thrusts used when choking), however the resident went limp in their chair.- Staff removed the resident from the dining room and lowered them to the floor. The resident had no palpable pulse, a code blue (medical emergency) was called, and Licensed Practical Nurse #3 initiated (chest) compressions.-Registered Nurse Supervisor #4 arrived on the unit and placed the automated external defibrillator pads on the resident; no heart rate or rhythm was noted, and no shock was advised. -Registered Nurse Supervisor #4 was unable to feel a pulse and Licensed Practical Nurse #7 did not hear a heartbeat.-Licensed Practical Nurse #8 arrived for the code and verified that Resident #14 had an order do not resuscitate per their Medical Orders for Life Sustaining Treatment form.-Compressions were stopped and the resident was pronounced dead at 12:20 PM.The 02/07/2026 Licensed Practical Nurse #3 progress note documented they became aware the resident was coughing in the dining room. Back pats were given, and the resident was moving air and was able to drink. Resident #14 appeared to be in distress and the Heimlich was attempted; the resident went limp in the chair and had a grey color to the lips and face. The supervisor was notified, and a code was called at 12:13 PM. The resident was lowered to the floor, there was no pulse felt, cardiopulmonary resuscitation was initiated at 12:13 PM. Do not resuscitate status was verified and cardiopulmonary resuscitation was stopped. Time of death was called at 12:22 PM by the provider.The 02/07/2026 Registered Nurse Supervisor #4 progress note documented they were called to the unit, the resident was unresponsive, and Licensed Practical Nurse #3 was performing cardiopulmonary resuscitation. Automatic External Defibrillator pads were placed on the resident with no shock advised, and the resident was still without a pulse. Licensed Practical Nurse #7 was unable (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to hear a heartbeat, the resident's pulse continued to be absent, and cardiopulmonary resuscitation was stopped when the resident was confirmed to be do not resuscitate status.The 02/09/2026 Nurse Practitioner #9 progress note documented they pronounced the resident deceased via phone with nursing at 12:22 PM on 02/07/2026. The cause of death appeared to be a cardiopulmonary event.During an interview on 02/18/2026 at 9:58 AM Licensed Practical Nurse #3 stated if a resident started to choke, they would start back pats; if that did not work the Heimlich was performed. If the resident went unresponsive, they would start to perform cardiopulmonary resuscitation. They checked the pulse, did mouth sweeps, suctioned, and got help. If there was no change and they happened to be a do not resuscitate, then cardiopulmonary resuscitation stopped. Resident #14 was choking and coughing. Back pats were given; the resident became limp, cyanotic, unresponsive and was then lowered to the floor. Staff started compressions immediately and called a code. When the resident's code status was determined to be do not resuscitate, compressions were stopped.During a follow-up interview on 02/18/2026 at 11:19 AM Licensed Practical Nurse #3 stated they provided Resident #14 with a sip of water, and the resident attempted to stand up out of the chair. They went limp and chest compressions were started at 12:13 PM. It took over two minutes to verify the resident's code status; and when identified, they attempted to stop compressions. They were instructed by Registered Nurse Supervisor #4 to continue compressions so they could suction the resident and ensure nothing was left in their mouth. Compressions were stopped at about 12:19 PM.During an interview on 02/18/2026 at 12:19 Registered Nurse Supervisor #4 stated they arrived on the third floor after having been notified and Licensed Practical Nurse #3 was performing cardiopulmonary resuscitation. Ideally, the resident's code status was checked prior to initiating cardiopulmonary resuscitation; they assumed the code status was checked as the Licensed Practical Nurse was performing cardiopulmonary resuscitation. They hoped that staff would check the Medical Orders for Life Sustaining Treatment prior to initiating compressions. Compressions were stopped when it was found the resident was do not resuscitate status.\During an interview on 02/18/2026 at 3:56 PM Licensed Practical Nurse #11 stated they started cardiopulmonary resuscitation if a resident was found unresponsive prior to checking the code status. 10 New York Code, Rules, and Regulations 415.3(e)(1)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews and interviews during the recertification survey, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of communicable diseases and infections for two (2) of five (5) residents (Residents #25 and #56) reviewed. Specifically, Resident #25 was on contact precautions and Activities Aide #14, and Certified Nurse Aides #15 and #16 entered the room without appropriate personal protective equipment; and Resident #56 was on enhanced barrier precautions and Licensed Practical Nurse #7 performed wound care without appropriate personal protective equipment. Findings include:The undated facility policy Contact Precautions for Infection Control, documented contact precautions were used for specific residents that were known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact. A contact isolation sign was placed on the door; gloves were worn when the resident's room was entered and removed prior to leaving the room. Gowns were worn when it was anticipated that they would have substantial contact with the resident, environmental surfaces, or items in the resident's room; or if the resident was incontinent, had diarrhea, an ileostomy, a colostomy or wound drainage that was not contained by a dressing.The facility policy Enhanced Barrier Precautions: Multidrug-Resistant Organisms, revised 04/28/2025 documented the purpose of enhanced barrier precautions was to protect staff and residents and to reduce spread through indwelling medical devices and wounds. Gowns and gloves were required during high-contact resident care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care. 1) Resident #25 had diagnoses including diabetes, open wound on left hip, and morbid obesity. The 01/02/2026 Minimum Data Set assessment documented the resident had intact cognition, a surgical wound with wound care, was independent for bed mobility, dependent transfers, and did not have multidrug-resistant organisms. The 04/02/2025 Comprehensive Care Plan, revised 06/11/2025, documented the resident had methicillin-resistant staphylococcus aureus infection (a bacteria resistant to many antibiotics) in their left hip wound. Interventions included contact isolation precautions, wearing gown and masks when changing contaminated linens and place soiled linens in bags marked biohazard.The 08/01/2024 physician order documented contact precautions for methicillin-resistant staphylococcus aureus infection to the left hip.During an observation on 02/17/2026 at 12:55 PM the resident's room had a contact precaution sign posted with a personal protective bin outside the room. Activities Aide #14 entered the resident's room without a gown or gloves. While in the room they looked through drawers and in the closet for shoes the resident requested. They used a wet towel to clean the resident's shoe; exited the room and placed the wet towel into a bin on the unit; and performed hand hygiene with hand sanitizer outside the next door in the hallway.During an observation and interview with Activities Aide #14 on 02/17/2026 at 01:01 PM they stated Resident #25 was not on contact isolation and they just had a wound. They did not follow contact precautions when they entered the room as they did not see the contact isolation sign on the door. They only donned gloves for the wet towel. Activities Aide #14 then went back into the resident's room without any personal protective equipment and grabbed a bag and laptop off the resident's bed and left the room.During an observation on 02/20/2026 at 1:11 PM Certified Nurse Aides #15 and #16 entered Resident #25's room without gowns or gloves. The resident was seated in their wheelchair next to a mechanical liftDuring an interview on 02/20/2026 at 1:15 PM Certified Nurse Aide #15 stated they knew when residents were on precautions by the sign outside their door. They were required to wear a gown and gloves in a contact room. They were not sure if Resident #25 was on contact precautions but when they saw the sign they assumed they must have been. They did not wear a gown when they transferred the resident as they were unaware the resident was on precautions at that time.During an interview on 02/20/2026 at 1:19 PM Certified Nurse Aide #16 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they knew a resident was on precautions by the sign on their door. They needed to wear a gown and gloves for a contact room and wash their hands with soap and water when they left. Staff wore gowns and gloves every time they were in contact with a resident during care. They performed perineum care on Resident #25 and was not sure if the resident was on precautions. They did not wear a gown while care was performed, and they should have. They stated they forgot to look at the sign over the door. 2) Resident #56 had diagnoses including diabetes and a Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer of the right heel. The 12/19/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for all activities of daily living, and had a Stage 4 pressure ulcer on the right heel.The 09/10/2024 Comprehensive Care Plan revised 01/15/2026 documented the resident was on enhanced barrier precautions for the pressure ulcer to the right heel. Interventions included maintain contact precautions at all times, use gowns and gloves when performing contact activities including wound care or any activity with close contact, and post signage outside the resident's door.The 06/24/2025 provider order documented to maintain enhanced barrier precautions due to right heel wound.During an observation on 02/17/2026 at 10:29 AM Resident #56 was sitting in a chair in their room. There were gowns outside their room in the personal protective equipment caddy.During an observation on 02/20/2026 at 10:55 AM Licensed Practical Nurse #7 performed wound care to Resident #56's right heel wound. They donned gloves prior to starting the treatment and did not don a gown. During an interview on 02/20/2026 at 12:42 PM Licensed Practical Nurse #7 stated enhanced barrier meant that they had to use personal protective equipment when they encountered a catheter, tube feed, or wound. They knew when a resident was on precautions because there was a sign outside their door and in their chart. They did not believe Resident #56 was on enhanced barrier precautions because their wound treatment was skin prep (type of cleanser treatment). After they checked the resident's chart, they confirmed that Resident #56 was on enhanced barrier precautions, and they should have worn a gown when they performed their treatment.During an interview on 02/23/2026 at 10:36 AM Registered Nurse Unit Manager #10 stated enhanced barrier precautions were used for residents who had foley catheters, wounds, and ostomy bags and required staff to wear gowns and gloves when performing wound care. Resident #56 was on enhanced barrier precautions. It was not appropriate for staff to complete wound care without wearing a gown and they needed to follow the sign. Contact isolation was similar to enhanced barrier precautions. They were unable to remember exactly what the contact isolation sign instructed but believed staff needed to wear a mask, gown and gloves with direct care. Resident #25 was on contact precautions because of their chronic left surgical wound. They did not believe Activities Aide #14 needed to wear personal protective equipment while in the resident's room or when they assisting the resident with their footwear. Staff should wear a gown and gloves when performing perinium care for Resident #25.During an interview on 02/23/2026 at 12:24 PM Infection Control Nurse #17 stated residents were on enhanced barrier precautions if they were at risk for infection. It was an extra layer of protection for staff and residents who had feeding tubes, foley catheters, ostomies and open wounds. A gown and gloves were worn when providing wound care to a resident on enhanced barrier precautions. Contact isolation was similar, but an infection was identified. They recommended a mask, gloves, and gown for contact isolation. Staff looked at the sign to find out what type of precautions it was and what to do. Perinium care should be performed wearing a gown and gloves. They were unsure if a gown or gloves were needed while touching resident belongings or helping with footwear. 10 New York Codes, Rules and Regulations 415.19(a)(b)