STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charles T Sitrin Health Care Center Inc	2050 Tilden Ave New Hartford, NY 13413

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46276 Based on interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not protect and promote the rights of the residents were maintained for 182 of 182 residents residing in the facility. Specifically, mail was not delivered to residents on Saturdays, thereby denying all residents the same rights provided to other citizens and residents of the United States. Findings include: The facility policy, Resident's [NAME] of Rights, revised 9/2024, documented each resident was encouraged and assisted throughout their period of stay, to exercise their rights as a resident, and as a citizen, or resident of the United States and of the State of New York. The undated facility policy, Resident Mail, documented all mail would be delivered by the post office mail carrier to the front desk receptionist in the main building who would then sort resident personal mail including cards and letters. Mail would then be placed into the house/unit mailboxes for pick up. A staff representative from the long-term houses will come daily to the main building to pick up the resident personal mail and distribute it to the appropriate resident location. During a resident group interview on 11/13/2024 at 11:38 AM, 7 of 7 anonymous residents stated they did not get mail delivered on Saturdays. The mail room was only open Monday through Friday, and they were unsure who delivered the mail. During an interview on 11/14/2024 at 12:02 PM, Front Desk Receptionist #2 stated mail was delivered to the front desk from the post office. The accounting office sorted through it and removed the bills. When the mail sorting was finished, the mail was placed in the mailroom and the long-term care housing unit secretaries picked it up Monday through Friday. Mail was not delivered to residents on Saturdays because it no one was available to pick it up on the weekends. During an interview on 11/15/2024 at 11:29 AM Unit Secretary #5 stated they delivered resident mail for the long-term care houses during the week. There was no mail delivery to residents on Saturdays. They assumed the post office delivered the mail to the facility but was unsure if anyone brought it to the residents. (continued on next page)

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

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

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 11/18/2024 at 11:12 AM Recreation Leader #6 stated they helped Unit Secretary #5 deliver mail on Wednesdays and there was no one there to deliver mail on Saturdays. If mail was delivered to the facility on Saturdays, residents would have to wait until Monday to receive it. During an interview on 11/18/2024 at 1:39 PM, Bus Driver # 8 stated they drove the transportation bus for the facility's adult day care home. They stated they go to the post office and pick up mail during the week for the facility and drop it off at accounting. They did not pick up mail on the weekends. During an interview on 11/19/2024 at 12:12 PM, the Administrator stated the mail was delivered during the week from the post office and the mail was then sorted and placed into the mail room. Staff would come pick up the mail and distribute it to the residents. Mail was not delivered from the post office on the weekends and the residents received no mail. 10NYCRR 415.3(d)(2)(i)

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NAME OF PROVIDER OR SUPPLIER Charles T Sitrin Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Tilden Ave New Hartford, NY 13413	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46276 Based on observations, record review, and interviews during the recertification and abbreviated (NY00353770 and NY00356334) surveys conducted 11/12/2024-11/19/2024, the facility did not make prompt efforts to resolve grievances for 1 of 1 resident (Resident #126) reviewed. Specifically, Resident #126 was missing their right hearing aid, and it was not recovered or replaced. Additionally, placement of both hearing aids was documented in the medical record after the right hearing aid was reported missing. The facility policy, Resident and Family Grievance Policy and Procedure, revised 7/2023, documented all residents/patients and their families would be informed of the steps necessary to communicate a formal grievance without fear of retaliation or barriers to service. Grievances could be through written or verbal communication. Such grievances would be brought immediately to the attention of the Director of Nursing and Corporate Compliance Officer for review and evaluation and they would work with staff to resolve the issue. If the resident/family member was dissatisfied with the resolution of the issue, they could contact the Administrator through written or oral communication and if still unsatisfactory, they could contact the Department of Health's centralized intake unit. The facility policy, Misappropriation (Missing or Damaged) Resident Property, revised 9/2023, documented upon receipt of an allegation of misappropriation of resident's property, a missing resident property form would be initiated by the staff member who was informed of the missing/damaged property. All information from the investigation would be documented on the missing property form under the applicable section. If it was determined the facility was liable, reimbursement would be based on either a receipt or the normal life expectancy of an item. Resident #126 had diagnoses of Parkinson's Disease (a progressive neurological disorder), neurocognitive disorder with Lewy bodies (degeneration of areas of the brain and brainstem), and dementia. The 12/20/2023 Minimum Data Set assessment documented the resident had hearing aids, had severely impaired cognition, required substantial/maximum assistance with bathing, personal hygiene, upper body dressing, and the resident considered it very important to take care of their personal belongings. The 12/19/2022 Registered Nurse #13 admission assessment documented the resident had hearing aids for both ears. The Comprehensive Care Plan initiated on 12/19/2022 documented the resident had an activity of daily living deficit related to dementia. Interventions included durable medical equipment and to see certified nurse aide care instructions. The 12/29/2022 Physician #22 order documented bilateral hearing aids every shift. The order was discontinued on 10/19/2023. The 9/2024 Medication Administration Records documented bilateral hearing aids; verify in bilateral ears every shift or in medication cart overnight with a start date of 10/19/2023 and an end date of 11/13/2024. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/2024 certified nurse aide task form documented: - on 9/5/2024 at 10:46 AM Certified Nurse Aide #30 documented the resident had both hearing aids present - on 9/5/2024 at 11:16 PM, Certified Nurse Aide #25 documented N/A. The 9/5/2024 at 10:24 PM Licensed Practical Nurse #16 progress note documented the resident's right hearing aid was reported missing on the 3:00 PM-11:00 PM shift by Certified Nurse Aide #25 during PM care. Certified nurse aide #25 removed the left hearing aid and placed it in a box on the resident's dresser. Licensed Practical Nurse #16 placed the box in the medication cart. A missing property form was initiated. The Resident Property- Missing or Damaged Property form initiated on 9/5/2024 and reviewed on 9/6/2024 by Registered Nurse #17 documented the resident's right hearing aid was reported missing during the 3:00 PM-11:00 PM shift on 9/5/2024 during PM care by Certified Nurse Aide #25. On 9/9/2024, Social Worker #27 documented they spoke with the family representative and the expectation was reimbursement for the right hearing aid. A receipt would be provided by the family representative and the approximate value was two-thousand five hundred dollars ($2,500.00). On 9/26/2024, the [NAME] President of Clinical Operations documented Administration stated the facility was not responsible for the resident's missing hearing aid if staff documented it was present during the day shift prior to it missing. The undated and untimed summary investigation report by the Administrator documented the resident had a brief interview for mental status score of 99 (severely impaired cognition), Parkinson's Disease and Lewy body dementia. The resident's right hearing aid was documented by staff as present prior to it missing. The resident may have removed it themself or it could have fallen out due to the resident leaning in their chair. The Administrator documented the Admission Agreement stated the facility was not responsible for the missing hearing aid unless it was due to negligence. The 9/2024 Medication Administration Record documented there were 23 days the resident's bilateral hearing aids were verified in both ears or in the medication cart after 9/5/2024 when the right hearing aid was reported missing. The 10/19/2023 Physician #22 order documented bilateral hearing aids every shift. The order was discontinued on 11/13/2024. The 10/2024 medication administration record documented there were 31 days the resident's bilateral hearing aids were verified in both ears or in the medication cart. The 11/13/2024 at 7:00 AM, Physician #22 order documented left hearing aid, verify in left ear every shift or in medication cart overnight. The November 2024 resident care instructions documented left hearing aid, verify in left ear every shift or in the medication cart. During an observation on 11/13/2024 at 11:43 AM, Resident #126 was sitting in their room. There were no hearing aids in the resident's room or in their ears. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/14/2024 at 10:26 AM, the resident was sitting in the dining room and was not wearing hearing aids in either ear. During an observation on 11/15/2024 at 10:41 AM, the resident was sitting in the with a hearing aid in their left ear only. The November 2024 medication administration record documented 12 days the resident's bilateral hearing aids were verified in both ears or in the medication cart including 11/13/2024, 11/14/2024, and 11/15/2024. During an interview on 11/13/2024 at 9:00 AM, the family representative stated the Resident's right hearing aid was missing, the resident could not manage their own hearing aids (taking them in or out), they complained to the facility and the facility refused to reimburse or replace the hearing aid. They had received several electronic mail communications from the [NAME] President of Operations stating the facility would not be responsible for the lost hearing aid. During an interview on 11/15/2024 at 10:11 AM, Certified Nurse Aide #3 stated Resident #126 was missing their right hearing aid. The resident had a green container their hearing aids were kept in. The nurses would place the hearing aids in the resident's ears in the morning and the certified nurse aids would remove them at bedtime. Certified Nurse Aide #3 stated the resident required total care and staff would have to put the hearing aids in for them. They stated the hearing aids were not working the evening the right hearing aid went missing. During an interview on 11/15/2024 at 10:19 AM, Certified Nurse Aide #26 stated the resident required total care and had hearing aids. Staff had to put the hearing aids into the resident's ears. Certified nurse aide #26 did not recall working the evening the right hearing aid went missing. The certified nurse aides would have to sign that they looked for hearing aids or other personal items before they did the laundry. During an interview on 11/15/2024 at 11:36 AM, Licensed Practical Nurse #4 stated they recalled hearing on the morning of 9/6/2024 that Resident #126's right hearing aid was missing. They searched the house, looked in the washers and dryers and in the Resident's room and hallway and could not find the hearing aid. Licensed Practical Nurse #4 stated they put the resident's hearing aids in their ears in the morning and the evening certified nurse aides took them out and gave them to the evening nurse. The resident could not put their hearing aids in or take them out independently. A missing property form was filled out by the Supervisor and turned into Administration. They stated the family wanted reimbursement for the hearing aid, but they did not know the outcome of the investigation. During an interview on 11/18/2024 at 12:20 PM, Social Worker #27 stated they were aware of Resident #126's missing right hearing aid. They stated the resident had a cognitive decline, sat in a recliner chair, and could not put their hearing aids in or take them out. If a resident's personal property was missing, a missing items form was completed by the staff who first noticed it missing, they in turn filled out their section and obtained the item's value and the form was sent to Administration. Social Worker #27 stated they told the family representative to seek out their insurance for coverage. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/18/2024 at 1:29 PM, the [NAME] President of Clinical Operations stated they were aware of Resident #126's missing right hearing aid, the resident was cognitively impaired and could not put their own hearing aids in or take them out. Their duties had been to assist with missing property investigations, and they filled out their section of the missing items form. When they finished their portion of the report they handed it to Administration. They stated Resident #126 was care planned for staff to put the hearing aids in and take them out every shift, but they were unsure if the facility was responsible for the lost hearing aid. They stated they had concluded that the facility was not liable for the missing hearing aid because nursing staff had documented the day before on 9/5/2024 that their hearing aid was present. During an interview on 11/18/2024 at 3:04 PM, Certified Nurse Aide #25 stated they were familiar with Resident #126, they had glasses and hearing aids. Nursing staff was responsible to put the hearing aids in and take them out during PM care or during naps. Certified Nurse Aide #25 stated they worked on the 3:00-11:00 PM shift on 9/5/2024 and the Resident's right hearing aid was already missing when they came on shift. During an interview on 11/19/2024 at 9:55 AM, the Administrator stated Resident #126 was missing a right hearing aid. They were familiar with the resident, and the resident could not manage their own hearing aids. The Administrator stated the resident's hearing aids were on their treatment plan and staff were responsible for putting them in their ears and taking them out in the evening. The Administrator stated the facility concluded they were not responsible for the lost right hearing aid because staff had documented every day, they were putting them in or taking them out. 10NYCRR 415.13(c)(I)(ii)

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	335475	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charles T Sitrin Health Care Center Inc	2050 Tilden Ave New Hartford, NY 13413

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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. 48052 Based on observations, record review, and interviews during the recertification and abbreviated (NY00356334) surveys conducted 11/12/2024-11/19/2024, the facility did not ensure residents maintained acceptable parameters of nutritional status for 1 of 5 residents (Resident #73) reviewed. Specifically, clinical nutrition staff did not assess Resident #73 following a significant weight loss. Findings include: The facility policy, Nutrition Assessments, dated 3/2022, documented the nutrition documentation was timed with [Minimum Data Set] schedules and care plan reviews or based on the resident's risk level and changes in nutritional status. Documentation should capture comprehensive and relevant findings and need for care plan revisions. The quarterly assessment was used to track resident status in-between comprehensive assessments to ensure risk indicators were monitored and interventions were implemented timely to minimize significant changes in resident status. The frequency of assessments was at least every 90 days but was also determined by the condition or nutritional risk level of the resident. Resident #73 had diagnoses including Alzheimer's disease, heart failure, and diabetes. The 9/27/2024 Minimum Data Set assessment documented the resident had severely impaired cognitive skills, it was important for the resident to receive snacks between meals, required set-up assistance for eating, received a mechanically altered diet, weighed 156 pounds, did not have an unplanned weight loss, nutritional status was triggered and was addressed in the care plan. The 2/27/2023 physician order documented the resident's weight was to be obtained on the first Wednesday of the month, every month during the day shift. The Comprehensive Care Plan revised 9/24/2024 documented the resident had a nutritional problem or potential nutritional problem related to severe cognitive deficit, advanced age, dysphagia (difficulty swallowing) diet restrictions related to altered consistency, moderate malnutrition, history of significant weight gain, and the potential for weight fluctuations due to daily diuretic use. The goal was for the resident to tolerate their pureed diet and to maintain adequate nutritional status by consuming greater than or equal to 75% of their meals. Interventions included the resident was to be fed by staff with drinks in mugs with lids and straws, honor food and fluid preferences, monitor the resident's intakes, monitor weights as ordered, monitor consistency tolerance, and provide and serve fortified food to compensate for periods of poor intake. The resident received Super Cereal (fortified cereal) at breakfast and fortified pudding at lunch three times a week. The resident's Kardex (care instructions) documented the resident required a deep divided dish, drinks in mugs with lids and straws, was to be fed by staff, was a hydration risk, and was on a regular diet with pureed texture. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/1/2024 Dietetic Technician #21's Nutrition Comprehensive Assessment documented the resident's most recent weight was taken on 9/10/2024 and was 156.4 pounds and they did not have a weight change. Their desired body weight range was 154-164 pounds. The resident's weight declined 3% since their June 2024 weight of 162 pounds. The resident's dietary preferences included fortified pudding at lunch three times a week and Super Cereal at breakfast. The resident's intakes were 25-75% for breakfast, lunch, and supper. The resident had fat wasting at their orbital and muscle wasting at their clavicles. The goals were adequate fluid intake, maintenance of nutrition parameters, acceptance of fortified foods/supplements, and to maintain their weight plus or minus 5 pounds. The 11/4/2024 sixty-day progress note by Physician #23 documented the resident continued a gradual and expected clinical decline and the resident's oral intake was diminished. The resident's creatinine had crept up. The provider discontinued the resident's diuretic. They documented the increase in creatine was likely a result of the resident's overall clinical and age-related decline with concurrent decreased oral intake. The certified nurse aide Point of Care response for What percentage of the meal was eaten? from 11/1/2024 to 11/18/2024 documented 9 out of 72 responses the resident consumed 75-100% of their meal. The resident refused their meal 17 of 72 responses. Resident #73's weight record documented the resident weighed 153.8 pounds on 10/4/2024 and 144.6 pounds on 11/6/2024 (a significant 6% weight loss in 1 month). There was no documented evidence Resident #73 was assessed by clinical nutrition staff after a 6% significant weight loss. Resident #73 was observed: - on 11/14/2024 at 8:35 AM in the dining room being assisted with breakfast by Certified Nurse Aide #18 who stated the resident did not want to eat their mashed potatoes and was spitting them out, but they liked the pureed fruit. - on 11/15/2024 at 12:14 PM, in the dining room being assisted with lunch by Certified Nurse Aide #19. The resident was declining to eat lunch but drank some orange juice. Licensed Practical Nurse #20 stated the resident usually liked sweets. Certified Nurse Aide #19 attempted to give the resident their fortified pudding and the resident accepted a couple of bites of the pudding. (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 11/19/2024 at 11:05 AM, Dietetic Technician #21 stated residents were assessed quarterly unless there was a significant change. They were responsible for all the assessments, plans of care, and interventions for the residents in long-term care. The nurses and Nurse Managers did not notify them of resident weight loss, it was their responsibility to look at the weekly or monthly weights. They stated they had not assessed Resident #73 since their last assessment on 10/1/2024. They stated they had written down the resident had a weight loss from 153 pounds to 144 pounds but had not looked at the resident. They stated a resident with significant weight loss should be assessed immediately with the onset of weight loss. They stated the goal for residents, unless they were on comfort care, was to maintain their weight as able and optimize their intakes. They were aware Resident #73's intake fluctuated but their goal would be for the resident's weight to trend back toward where it was. They stated they reviewed provider progress notes when they updated the care plans. Unless the weight order was discontinued their goal for a resident would always be to maximize their intake and maintain their weight. They stated it was important to assess a resident's weight loss when it happened as the resident's calorie needs may need to be calculated at a different rate and higher calorie interventions may need to be implemented. During an interview on 11/19/2024 at 10:49 AM, Physician #22 stated they expected Resident #73 to continue to decline. They stated they were unaware if the registered dietitian or dietetic technician were aware of the resident's decline. They stated they expected the resident to continue to decline and ideally, they would like the resident to continue to consume a normal intake, but it was unlikely due to their advanced dementia with diminished hunger and thirst. 10NYCRR415.12(i)(1)