STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335475	A. Building B. Wing	05/28/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interviews during the abbreviated survey (NY00341115), the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care person-centered care plan, and the resident's choices for one (1) of three (3) residents reviewed (Resident #1). Specifically, Resident #1 was reported by family to be choking on liquids and there was no documented evidence the resident was assessed by a qualified professional to determine if a modification to their diet was required. Findings include: The facility policy Acute Change of Condition, revised ,d+[DATE], documented all staff were responsible for identifying and reporting a change in a resident's condition. The licensed practical nurse initiated the Acute Change in Condition Communication Form and reported clinical findings to the registered nurse. The registered nurse was to do the following: review the form; assess the resident's symptoms, mental status and physical function; email the Acute Change in Condition Form to the group; contact the physician; communicate with the resident's family to discuss the change in condition; document their assessment in a progress note, any other observations, nursing interventions, notification of the physician and any new orders; continue to monitor following initiation of treatment; and update the provider if there was no improvement or further decline. The provider would review the findings and possible cause of the change in condition with the nurse and develop a plan for initial workup and treatment. The provider would document in the electronic record. Resident #1 had diagnoses including dementia. The [DATE] Minimum Data Set Assessment documented the resident had severely impaired cognition, required set-up or clean-up assistance with eating, and was not on a mechanically altered diet. The [DATE] Refusal of Treatment Resident Release Form, signed by the resident's family member documented the family member refused the resident's recommendations for a modified soft diet. The family was aware the resident was at risk of aspiration, illness, and death according to the signed release. The [DATE] physician order documented regular diet, regular texture, thin consistency. The [DATE] Comprehensive Care Plan documented the resident had a nutritional problem. Interventions included to monitor tolerance of diet consistency, consult speech therapy as needed, and staff were to notify the provider of change in condition requiring interventions/plan of care changes. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] hospital report documented the resident had an unwitnessed fall and was found in a large pool of blood from a lacerated forehead. The resident's eyelids were edematous (swollen) and bruised and a computed tomography scan (specialized x-ray) showed multiple nasal fractures and possible nasal septal (center of nose) fracture. The [DATE] at 2:36 PM Registered Nurse #10 progress note documented the resident returned from the hospital and was taking in minimal oral liquids and nothing nutritionally due to injury to their nose that did not allow the resident to breath effectively. The [DATE] Physician #9 progress note documented the resident returned from the hospital in some pain, intakes were low, and they hoped pain control would help. New orders included to start 2 liters of normal saline (mixture of water and salt) via intravenous route and a fentanyl patch (narcotic medication delivered through the skin) would be added for pain. The [DATE] at 2:24 PM Registered Nurse #10 progress note documented the resident still had decreased oral intake, complained of a sore throat, and was able to clear oral secretions on their own. The [DATE] at 9:58 PM Licensed Practical Nurse #3 progress note documented the resident's family reported the resident was choking on liquids. Licensed Practical Nurse #3 checked the resident's mouth, and the resident had no liquids in their mouth. There was no documented evidence a qualified professional was notified to assess the resident after they were reported choking. The [DATE] to [DATE] Interdisciplinary Team progress notes and physician progress notes did not address concerns related to the resident's alleged choking on liquids. There were no physician orders related to diet modification and no therapy screenings completed during this time. The Comprehensive Care Plan was not updated to address swallowing concerns. The [DATE] at 2:30 PM Registered Nurse #10 progress note documented the resident complained of shortness of breath and wheezing in their lungs. A chest x-ray obtained showed pneumonia. New orders were implemented for Invanz (antibiotic) intramuscularly (administered into a muscle), oral steroids (medication to decrease inflammation), and breathing treatments (inhaled medications). The [DATE] at 2:22 PM Registered Nurse #10 progress note documented staff reported the resident had increased lethargy, had a fever, and was not rousable. Respirations were increased and the resident had increased oral secretions. The provider was notified and ordered morphine and Ativan (narcotic medications). The [DATE] at 12:42 PM Registered Nurse #20 progress note documented the resident was found expired. The [DATE] Autopsy Report documented the resident's cause of death was aspiration pneumonia complicating facial trauma. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 8:31 AM, Licensed Practical Nurse #3 stated when a resident had a change in condition, they took vital signs, documented in a progress note, and called the supervisor to assess. When Resident #1 fell , they had a gash on their forehead and a bloody nose. There was no bruising. When the resident returned from the hospital, their whole face was bruised. On [DATE], they could not recall if they notified a supervisor about the alleged choking. They stated it was their normal routine to notify a supervisor when a resident had a change in condition because they did not want to take any chances. During a telephone interview on [DATE] at 11:24 AM, Registered Nurse #10 stated they were the current Assistant Director of Nursing and was Resident #1's Unit Manager when they were at the facility in 2024. They expected a registered nurse to be notified of a resident's change in condition so the registered nurse could assess the resident. The physician and family should be notified, and a progress note documented. If a family reported a resident was choking on liquids, they expected a registered nurse be notified for an assessment because the resident would be at risk of aspiration. They were not aware there was no registered nurse assessment completed on [DATE] and there should have been an assessment. During a telephone interview on [DATE] at 10:33 AM, Speech Therapist #19 stated they expected a supervisor assessment if a family reported a resident was choking on liquids. Any nurse could generate a referral to speech therapy so therapy could assess, and they expected a therapy referral for a resident choking on liquids. When Resident #1 was documented as choking on liquids, this was a change in condition for the resident, especially with the recent nasal fracture, and they expected the resident to be assessed by a supervisor and referred for speech therapy. Even with the signed consent form documenting the family refusing the modified solid foods, the resident should have had a medical follow up for the change in condition with liquids. 10NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34465 46276 Based on record review and interviews during the abbreviated survey (NY00323986), the facility did not ensure residents received adequate supervision and assistance devices to prevent accidents for one (1) of three (3) Residents (Resident #2) reviewed. Specifically, Resident #2 sustained a fracture of unknown origin to their left arm. The facility investigation identified family members were known to have transferred the resident and there was no evidence the family was educated on safe transfer techniques prior to the identification of the fracture. Findings include: The facility policy Transferring/Ambulation of Residents, revised 7/2002, documented residents were transferred or ambulated as indicated by the physical therapist's recommendations and/or the physician's/physician assistant's order. The transfer and/or ambulation procedure must be adhered to at all times and recorded in the resident care plan. The policy did not include parameters for non-staff transfers. Resident #2 had diagnoses including cerebral vascular accident (stroke), left-sided hemiplegia (paralysis), osteoporosis (weak and brittle bones), and dementia. The 7/14/2023 Minimum Data Set assessment documented the resident had severely impaired cognition, had a stroke and left sided paralysis, and required extensive assistance of one for stand/pivot transfers. The 2/21/2022 Physical Therapist #15 Physical Therapy Discharge Summary documented the resident was able to perform bed to chair transfers with maximum assistance of 1 staff, but remained inconsistent, often due to being resistive and refusing care. Recommendation to nursing included maximum assistance of 2 staff for transfers. The Comprehensive Care Plan revised 4/2023, documented the resident had impaired mobility, range of motion, balance and endurance related to cerebral vascular accident/hemiparesis/hemiplegia. Interventions included durable medical equipment; left sided quarter bed rail; and for bathing, dressing, and toileting, refer to the resident care instructions. The care plan did not address the family assisting the resident in transfers or ambulation. The 9/14/2023 (prior to arm injury) resident care instructions documented Resident #2 required extensive assistance of one for a stand/pivot transfer, was independent and self-propelled backwards in their wheelchair, required extensive assistance for dressing upper/lower body, and was non-ambulatory. The 9/12/2023 at 11:56 AM Licensed Practical Nurse #12 progress note documented the resident complained of left arm/shoulder pain. Their left arm was paralyzed from a stroke and was more flaccid (limp) than usual. There was no bruising or redness observed. The physician and supervisor were made aware. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence Resident #2 was assessed by a qualified professional on 9/12/2023 after complaining of left arm/shoulder pain. Nursing progress notes completed by Licensed Practical Nurse #12 documented: - on 9/13/2023 at 8:41 AM, the resident refused care and yelled at the certified nurse aide. The resident could be heard hollering down the hall. At 8:50 AM, they were moved to the dining room for breakfast and they refused to eat. - on 9/13/2023 at 1:36 PM, the resident had continued complaints of left arm/shoulder pain, and their left arm continued to be more flaccid than normal. Nurse Practitioner #18 went in to see the resident and the family representative was present. An x-ray of the left arm and shoulder and routine Tylenol (pain reliever) were ordered. The 9/13/2023 at 1:59 PM nursing progress note by Registered Nurse #10 documented the resident had a new order for an x-ray and family was present and aware. The 9/13/2023 (untimed) physician order documented x-ray to left shoulder and humerus (arm bone) one time for one day. The 9/13/2023 at 1:45 PM x-ray report documented two views of the left shoulder were completed. Impression was an acute fracture of the proximal (near) humerus (arm bone). The 9/13/2023 (untimed) physician telephone order documented apply immobilizer sling to affected extremity. Licensed practical nurse to confirm placement and fit every day on every shift for left humerus fracture. The 9/13/2023 at 9:56 PM Accident/Incident report completed by Registered Nurse #10 documented they were notified Resident #2 had bruising to their left arm on their biceps (muscles on the front side of the upper arm) and triceps (muscles on the back of the upper arm). The bruise was greenish purple in color and measured 1.5 centimeters by 0.5 centimeters. There were no injuries noted prior to or after the incident. Contributing factors were gait imbalance (the way a person walks), weakness and incontinence. The resident had an immobilizer in place to their left arm, was resting in bed, and denied any pain or discomfort. The medical provider and the family representative were notified. The 9/14/2023 Registered Nurse #10 written statement documented upon investigation, family and staff often transferred the resident and had not received proper training from facility staff to do this. Family was told they needed to receive training from the therapy department for any further transfers. The 9/14/2023 (untimed) Investigative Summary report completed by the Assistant Director of Nursing documented the resident had an injury of unknown origin. Witness statements were obtained, and abuse was ruled out based on staff, resident, and family representative interviews. Based on witness statements and staff interviews, it was discovered prior to the incident (injury) family transferred the resident to and from the bathroom, recliner, and bed without staff in the room. An injury from the resident's diagnoses, lack of assistance with transfers, or low energy with those transfers could not be ruled out. The resident's care plan was updated, and a physical therapy referral was placed for transfer training for the family. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/14/2023 at 2:11 PM Physical Therapy referral by Licensed Practical Nurse #12 documented family transferred the resident at times and a referral was needed for transfer training. There was no documented evidence Resident #2's family received transfer training prior to the injury identified on 9/14/2023. The 9/18/2023 at 2:47 PM physician progress note documented the resident was seen for a sick visit and had sustained a left humeral fracture. No rough or mishandling of the resident occurred per resident and family interviews and no recent falls were documented. The resident had a history of stroke with left-sided paralysis and osteoporosis and the loss of movement could have contributed to worsening osteoporosis. The physician documented they understood staff as well as family transferred the resident and even if best outcomes were intended, those fractures could have occurred. There was no evidence the fracture was related to a fall or mishandling of the resident. During an interview on 5/19/2025 at 11:47 AM, Certified Nurse Aide #11 stated Resident #2 required assistance of 1 staff with the use of a gait belt (belt used to assist with transfers), could bear weight on one leg and pivot. The resident's family often transferred the resident to the bathroom and then rang the bathroom call light for assistance. The family would also transfer the resident to the recliner or into bed after lunch. Certified Nurse Aide #11 told the nurse the family transferred the resident but could not recall the date. On 9/13/2023, the aide reported the resident's left arm appeared more flaccid than normal and their left arm had bruising. They had not noticed any bruising prior to that day. Certified Nurse Aide #11 stated the family was trained on transfers after the resident was discovered to have a fractured arm. During an interview on 5/20/2025 at 9:55 AM with Licensed Practical Nurse #12, they stated Resident #2 required extensive assistance from staff for all their activities of daily living except eating. They transferred to the bathroom with assistance of one and would grab the bars. They would also grab the rail on the bed with transfers. Licensed Practical Nurse #12 was aware the family transferred the resident long before the injury to their left arm. The nurse thought Physical Therapy provided education on transfers to the family. If they witnessed family assisting with a transfer, they would have notified their supervisor and documented it. They did not see any notifications or training documented. During an interview on 5/20/2025 at 2:10 PM, the Director of Therapy Services stated Resident #2 was discharged from physical therapy on 2/21/2022. At the time of discharge, the resident required extensive assistance of 2 for transfers and could stand and pivot. The Director of Therapy stated they were not aware family transferred the resident and there was no documentation of family education for transfers. If family was transferring the resident, they would want to be notified and would have a discussion. They relied on nursing to put a referral into therapy for notification if family education was needed. If nursing had knowledge of family transferring the resident, they should have submitted a referral. It was important to educate family for resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 10:33 AM, Physical Therapist #14 stated Resident #2 was low functioning, could not ambulate and sat in a reclining chair. The resident transferred with a stand/pivot method for toilet transfers with extensive assistance of one staff. They did not recall doing any recent evaluations. They were not aware family transferred the resident prior to their injury. If they had been notified the family was transferring the resident, they would have educated them for safety. They did not recall giving the family any transfer education and would have recommended family not transfer Resident #2 due to their diagnosis of stroke as it was not safe. They stated nursing should have placed a referral for physical therapy if they knew the family had transferred the resident. During an interview on 5/22/2025 at 2:50 PM, the Director of Nursing stated Resident #2 sustained a fracture to their left arm and they completed an investigation. They were alerted by Certified Nurse Aide #11 during their investigation family transferred the resident prior to the injury. They had no prior knowledge of family transferring the resident. They stated they did not witness any family transfers and if they had witnessed it, they would not necessarily have put a physical therapy referral in if they thought the family transferred the resident safely. There was no policy addressing family transferring a resident or training for transfers. They expected to be notified if other nursing staff witnessed family transferring the resident if they thought it was unsafe, then they would put a referral into therapy for transfer training. They stated they knew the resident's family had transfer training after the injury due to a referral being placed. 10NYCRR 415.12 (h)(1)