| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335475 | A. Building<br>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<br>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<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>46276<br><br>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.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |



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

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| F 0550<br><br>Level of Harm - Potential for minimal harm<br><br>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.<br><br>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.<br><br>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.<br><br>10NYCRR 415.3(d)(2)(i) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>46276<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The 12/19/2022 Registered Nurse #13 admission assessment documented the resident had hearing aids for both ears.<br><br>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.<br><br>The 12/29/2022 Physician #22 order documented bilateral hearing aids every shift. The order was discontinued on 10/19/2023.<br><br>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.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 9/2024 certified nurse aide task form documented:<br><br>- on 9/5/2024 at 10:46 AM Certified Nurse Aide #30 documented the resident had both hearing aids present<br><br>- on 9/5/2024 at 11:16 PM, Certified Nurse Aide #25 documented N/A.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>The 10/19/2023 Physician #22 order documented bilateral hearing aids every shift. The order was discontinued on 11/13/2024.<br><br>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.<br><br>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.<br><br>The November 2024 resident care instructions documented left hearing aid, verify in left ear every shift or in the medication cart.<br><br>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.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>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.<br><br>10NYCRR 415.13(c)(I)(ii) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>48675<br><br>Based on record review and interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not ensure residents were screened for serious mental disorders, intellectual disabilities, and related conditions prior to admission to the facility for 1 of 35 residents (Resident #104) reviewed. Specifically, there was no documented evidence Resident #104 had a Preadmission Screening and Resident Review Level I completed by a qualified screener prior to admission to the facility to determine if the resident had a mental disorder, intellectual disability, or a related condition.<br><br>Findings include:<br><br>The facility policy, New York State Department of Health Screen Form, revised 1/2017, documented a screening form would be completed preadmission and when a resident's condition or circumstances change such that the outcome indicated a change in placement or as a psychiatric condition developed or when a nursing home admission that was originally determined to be less than 30 days exceeded beyond that time. The medical records department would be notified if a level II review was required.<br><br>The facility policy, Admission of Individuals with Mental Illness/Developmental Disability, dated 11/2023, documented the [New York State Screen] form (DOH-695) would be reviewed by the Director of Admissions or designee as part of the decision making process. If item #23 (mental illness diagnosis) or items #24, #25, #26 are checked 'yes' then a level II Preadmission Screen for Resident Review must be completed as follows:<br><br>-for individuals who trigger for a mental illness, the level II Preadmission Screen for Resident Review must be completed. Results of the level II Preadmission Screen for Resident Review must be received by the facility and must indicate that skilled nursing facility placement is appropriate prior to offering a bed/admitting the individual. Should the assessments indicate that skilled nursing facility placement was not appropriate, the facility would not admit the individual.<br><br>Resident #104 had diagnoses including dementia with other behavioral disturbances. The 6/10/2021 Minimum Data Set admission assessment documented the resident was admitted from an acute hospital, they did not require a level II Preadmission Screen Resident Review, they had severely impaired cognition, and required extensive assistance with most activities of daily living.<br><br>There was no documented evidence Resident #104 had a Level I Preadmission Screen Resident Review completed prior to admission to the facility as required.<br><br>During an interview on 11/19/2024 at 1:30 PM, the Administrator stated they were unaware every resident needed a Preadmission Screen Resident Review completed and they would defer all questions to social services.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/19/2024 at 1:36 PM, Director of Social Services #39 stated before a resident was admitted to the facility, hospitals would complete a Patient Review Instrument and Preadmission Screen for Resident Review (New York State Department of Health form 695) and send it to them. It was a source of referral, and they would always get the Patient Review Instrument and screen from either the hospital or transferring nursing home. All Residents from New York State were required to have a screen completed. Resident #104 came from another state, so they did not have one completed. A Level I screen determined the level of care required and if a resident was appropriate for a nursing home/skilled care. If they were able to receive a lower level of care, the screening would be a formality for their facility. If the Level II screen was triggered by the Level I screen for developmental disability or serious mental illness, it would list what special services were needed for the resident. If a resident came from another state, services would be determined based on the records from the transferring facility. Director of Social Services #39 stated they did not think other states completed a Preadmission Screen for Resident Review. Resident #104 did not have either a mental illness or disability or they would not have admitted them. If they felt the resident required more care, they would have completed a screening, but it would have been completed after they were admitted and would not be accurate.<br><br>10NYCRR 415.11(3) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>35045<br><br>Based on record review and interviews during the recertification survey conducted 11/12/2024- 11/19/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for each resident to meet the medical and nursing needs identified in the comprehensive assessment for 1 of 5 residents (Resident #2) reviewed. Specifically, Resident #2 received an anticoagulant (blood thinner) medication and did not have an individualized care plan for this medication.<br><br>Findings include:<br><br>The facility policy, Anticoagulation Therapy, revised 9/2024, documented all residents receiving anticoagulant therapy would have the reason for the therapy included on their care plans. If the resident had an order for anticoagulant therapy on admission, the admitting registered nurse would include the reason for it in the care plan. If the resident was started on anticoagulant therapy after admission, the nurse receiving the order for anticoagulant therapy would ensure that the care plan would be updated with this information. The care plan would be updated concerning anticoagulant therapy by the admission nurse or the nurse receiving the new order whenever anticoagulant therapy was started, and each 30/60-day order reviewed.<br><br>Resident #2 had diagnoses including dementia and atrial fibrillation (irregular heartbeat). The 10/18/2024 Minimum Data Set assessment documented the resident had intact cognition and was taking high risk medications during the last seven days including an anticoagulant.<br><br>The 1/18/2024 physician order documented Eliquis (apixaban, an anticoagulant) oral tablet 5 milligrams give one tablet by mouth every 12 hours for blood thinner.<br><br>There was no documented evidence the use of an anticoagulant was included in the resident's Comprehensive Care Plan initiated 1/18/2024.<br><br>The November 2024 Medication Administration Record documented the resident received Eliquis 5 milligrams twice a day as ordered from 11/2/2024 through 11/15/2024.<br><br>During an interview on 11/13/2024 at 8:59 AM, Resident #2 was not sure what medications they took during the day.<br><br>During an interview on 11/19/2024 at 12:23 PM, Registered Nurse Unit Manager #9 stated the resident did not have a care plan for their anticoagulant and there should have been one in place. The Registered Nurse Manager stated they were responsible for updating residents' care plans with medications and any changes to their care. They did not know why the resident's Eliquis was not included in the care plan. Anticoagulants put the resident at risk for bleeding and staff would need interventions in place to keep the resident safe. They stated they should have updated the care plan when the resident arrived to long term care and with the recent completion of the Minimum Data Set update.<br><br>10 NYCRR415.12 (e)(2) |

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>48052<br><br>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.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| | 335475 | A. Building<br>B. Wing | 11/19/2024 |

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| Charles T Sitrin Health Care Center Inc | 2050 Tilden Ave<br>New Hartford, NY 13413 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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<br><br>concurrent decreased oral intake.<br><br>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.<br><br>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).<br><br>There was no documented evidence Resident #73 was assessed by clinical nutrition staff after a 6% significant weight loss.<br><br>Resident #73 was observed:<br><br>- 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.<br><br>- 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.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>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.<br><br>10NYCRR415.12(i)(1) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>48052<br><br>Based on observations, record review, and interviews during the recertification survey conducted 11/12/24-11/19/24 the facility did not ensure a resident who displayed or was diagnosed with dementia, received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #40) reviewed. Specifically, the facility did not follow Resident #40's individualized care plan interventions that included the resident's customary routines, interests, preferences, and choices to enhance their well-being and to guide staff in managing the resident's care.<br><br>Findings include:<br><br>The facility policy, Caring for Residents with Dementia, revised 1/2024, documented residents would have regular cognitive evaluations and care plans would be changed accordingly. The resident would have an individualized care plan to have their specific needs addressed which included behavior management and daily living activities. The care plan would be adapted to the resident's current stage of dementia and updated as needed. An individualized behavior care plan would be implemented that listed to prevent or manage behaviors.<br><br>The facility policy, Behavioral Management Plans, dated 10/2015, documented behavior management plans would be developed and regularly reviewed for residents who had maladaptive behaviors that were disruptive or dangerous to other residents and staff. Behavior plans would be utilized by staff to promote positive, appropriate behaviors and interactions. Behavior plans included identification of behavior problems, triggers for behaviors, signs of escalation, and interventions. Behavior management plans would be placed in the [certified nurse aide] task book on each unit and staff was responsible for reviewing the plan prior to each shift. Behavioral plans would be reviewed monthly, and any changes are approved by the behavioral committee.<br><br>Resident #40 had diagnoses including Alzheimer's disease, dementia with other behavioral disturbances, and major depressive disorder. The 8/28/2024 Minimum Data Set assessment, documented the resident had severely impaired daily decision making skills, fluctuating inattention, continuous disorganized thinking, physical behavior symptoms that did not affect their participation in activities 1-3 of 7 days, it was important to the resident to have family involved in care discussions, and liked to read books, magazines, and newspapers, listen to music, participate in their favorite activities, and do things with groups of people.<br><br>The 3/3/2023 Comprehensive Care Plan documented the resident had the potential to be physically aggressive by kicking, slapping, and biting related to their dementia. Interventions included to follow the resident's behavior plan prior to administration of as needed medication.<br><br>The resident's person-centered care plan of care documented the resident preferred to sleep in and not be disturbed for breakfast and medication administration. Their adult children were agreeable that the resident be allowed to sleep in. Interventions included to feed the resident and give medications when the resident awoke.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The revised 5/29/2024 Comprehensive Care Plan documented the resident was dependent on staff for meeting their emotional, intellectual, physical, and emotional needs due to the advanced dementia and cognitive deficits. Interventions included the resident preferred television shows including Law and Order, NCIS, Wheel of Fortune, Jeopardy, and baseball. Engage the resident in simple tasks such as looking at magazines, manicures, holding a doll, going for walks, and talking/reminiscing.<br><br>The undated Kardex (care instructions) documented to read the resident's behavior plan when the resident was restless or agitated.<br><br>The resident's behavior plan in the certified nurse aide task book documented the resident was to go to the dining room table for meals and staff was to give the resident objects to fidget with such as stuffed animals, puzzle pieces, magazines, and pop-up toys. Staff was also to provide activities of interest to the resident to do while seated in their recliner chair. The resident enjoyed busy work such as organizing papers or looking at magazines.<br><br>The 11-7 Get Up List documented the resident was to be dressed and out of bed on the 11:00 PM to 7:00 AM shift.<br><br>Resident #40 was observed:<br><br>- on 11/12/2024 at 11:28 AM, sitting in their wheelchair in front of the television in the common area. They were alternating between having their eyes open and closed while they leaned forward and back with their legs crossed. The resident was reaching forward out in front of themself toward the air or touching their face and hair. They were moving their upper body and appeared restless with slow movements. At 11:36 AM, the resident leaned forward to the right, bent at the waist in their wheelchair, as if they were reaching for something and then sat back.<br><br>- on 11/13/2024 at 8:22 AM, sitting in the dining room, pushed up to the table in their wheelchair, with nothing in front of them except a placemat. At 8:48 AM, the resident was assisted with breakfast by staff.<br><br>- on 11/14/2024 at 8:33 AM, in the dining room pushed up to the table in their wheelchair and had completed breakfast. The news with the weather was on the common area TV and the resident had their eyes closed as they slightly rocked back and forth. At 11:55 AM, the resident was sitting at the table in the dining room with nothing in front of them. They had their eyes closed and was periodically rocking back and forth with their left hand intermittently touching their face and picking at their shirt. At 12:23 PM, a plate was placed in front of the resident by a certified nurse aide who sat to assist the resident with their meal.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 11/15/2024 at 9:29 AM, in their room in their wheelchair, parallel with the end of the bed. The television was playing a Christmas movie with the sound on. The resident leaned slightly forward in their chair with their eyes open and legs crossed. The resident's fingers moved continuously. At 11:21 AM, the resident was sitting at a table in the dining room with their hands in their lap. The resident had their head tilted back with their mouth open. There was nothing in front of the resident except their place mat and silverware. At 11:23 AM, the resident's eyes were still closed, and they began to pinch at their sweatshirt. At 11:35 AM, the resident leaned forward and backward in their wheelchair at the dining room table while they moved and crossed their legs. The resident was intermittently moving their hands back and forth under the table and flexing their fingers. At 11:43 AM, the resident had their arms crossed in front them while they rocked back and forth. They lifted their left arm then flexed their left hand against their right arm and grabbed their sweatshirt sleeve. They walked their fingers on their arm and the wheelchair arm. They leaned forward in their seat and then backward. At 12:00 PM, they were pulling at the blanket in their lap. At 12:13 PM, Licensed Practical Nurse #20 sat next to the resident and greeted them while the resident moved their hand back and forth on the empty placemat.<br><br>- on 11/18/2024 at 11:04 AM, in their wheelchair in their room with the Hallmark Channel on their television while they moved their hand in a fidgeting manner with their eyes closed. At 11:12 AM, the resident sat forward in their wheelchair with their eyes open and awake while they grabbed at their pant leg and their shirt sleeve and then crossed their left leg over their right. The resident was angled slightly, toward the corner and window in the room, away from the television, so it was not in direct line of sight. The Hallmark Channel was on the television and the resident had nothing else in front of them. At 11:28 AM, the resident was brought into the dining in their wheelchair and pushed up to table. The resident was staring ahead with their eyes open and their hands in their lap. The resident had only the placemat and silverware in front of them. There were no distractions or fidget items provided. The resident's leg and hands were moving under the table. They rocked themselves forward and back while readjusting their position in the chair. At 11:30 AM, the resident was fidgeting in their chair, moving their hands, and readjusting their body position frequently.<br><br>During an interview on 11/18/2024 at 11:47 AM, Social Worker #27 stated the social work department was responsible for cognitive loss and behavior care plans. The nursing department also assisted with a resident's behavior care plan. Social Worker #27 stated they created the behavior plans that were kept in the certified nurse aide task books. The behavior plans were updated as needed and they were reviewed at least yearly to ensure they were up to date. They created the behavior plans by consulting with the staff in the house the resident resided. They also spoke with the resident if the resident could make their needs known and with a resident's family to incorporate likes and dislikes. The staff were aware of the interventions on the behavior plan and the plans were reviewed by the interdisciplinary team prior to being placed in the task book. They stated Resident #40 had their restlessness included on their behavior plan. They stated the staff should be giving the resident items to occupy them in the dining room, particularly a baby doll as that was a calming technique for the resident.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/18/2024 at 1:37 PM, Certified Nurse Aide #19 stated staff was supposed to review the task book every day because it could change. They reviewed the resident behavior plans as needed and received report from the nurse if anything had changed. They stated as part of Resident #40's behavior plan they were supposed to have two certified nurse aides assist the resident because the resident would grab and fight during care. They stated the resident was an early get up from night shift and was always up prior to the start of their shift on the day shift. They stated sometimes they give the resident teddy bears in the dining room, and the resident grabbed onto them as well as an activity blanket. They stated the items were usually given after breakfast when the resident was up in their chair. They stated the resident was sometimes given items to assist with their fidgeting before meals but not always.<br><br>During an interview on 11/18/2024 at 1:49 PM, Licensed Practical Nurse #34 stated certified nurse aides were supposed to review the task binder every shift which included the behavior plans for the residents. The certified nurse aides should follow what was on the behavior plan. They stated if a resident's care plan included to allow the resident to sleep in, they should not be on the early get up list. If a behavior plan recommended to give the resident something to occupy them in the dining room while awaiting a meal, they should be given what was recommended. They stated they did review the behavior plans in the task book but were unaware Resident #40 was to have items to fidget with when brought to the dining room early.<br><br>During an interview on 11/18/2024 at 1:59 PM, the Assistant Director of Nursing stated the certified nurse aides, and the licensed practical nurses should look at the task binder on the unit prior to each shift. They stated if a behavior plan was in place, staff were supposed to follow it. If a resident had a care plan indicating they preferred to sleep in and their family was aware the resident may miss a meal or medications, they should not be on the early get up list.<br><br>During an interview on 11/19/2024 at 11:50 AM Registered Nurse Unit Manager #9 stated they left it up to the charge nurses to determine who was on the early get up list. They stated Resident #40 was on the early get up list when their care plan stated they preferred to sleep in as they had overlooked the fact that the resident liked to sleep in. They stated the resident had advanced dementia and had been taken off most of their medications and was on comfort care per the family wishes. The resident used to fall quite a bit and it was safest to get the resident up. They stated they removed the preference to sleep in from the resident's care plan. They stated they had discussed potentially removing the behavior plan from the resident completely, but it had not been done yet. They stated if the resident's behavior plan documented to give the resident objects to fidget with when in the dining, they staff should have them.<br><br>10NYCRR 415.12 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>33421<br><br>48052<br><br>Based on record review and interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not ensure residents received psychotropic drugs necessary to treat a specific condition and had behavioral interventions in place, and did not ensure residents as needed (prn) psychotropic drugs were limited to 14 days or had documented physician rationale and indications for extending the drug past 14 days for 2 of 7 residents (Residents #17 and #62) reviewed. Specifically Resident #17 received an antipsychotic medication and did not have an appropriate indication for use and did not have a person centered care plan with non-pharmacological interventions for behaviors; and Resident #62 had an as needed order for Haldol (antipsychotic) that was not limited to 14 days and there was no rationale and indication for the continued use of the medication documented by the physician.<br><br>Findings include:<br><br>The facility policy, Ordering and Administration of Psychotropic Medications, revised 12/2018, documented the use of psychotropic medication was based on the medical doctor or nurse practitioner's order to treat a specific condition after a full review of the resident's medication regiment and medical history. The medication selected would be chosen with consideration as to the most effective medication with the fewest possible side effects and used in the lowest possible dose. The interdisciplinary team would also review the resident's behavior and recommend alternative means of treating in addition to medication which would be included on the resident's plan of care. Psychotropic medications should not be used solely for poor self-care, restlessness, occasional crying/yelling, impaired memory, or being uncooperative with care. Routine psychotropic medication was reviewed by the medical doctor or nurse practitioner at scheduled 30- and 60-day visits. As needed psychotropic medication orders were limited to 14 days. Antipsychotic as needed medications could not be extended beyond 14 days and to be renewed, the medical doctor or nurse practitioner made a face-to-face evaluation for the appropriateness of the medication every 14 days. Specific resident behaviors were documented in the electronic medical record. The behavior documentation was utilized for tracking of the number and type of ongoing behaviors to determine effectiveness of medication and the potential for gradual dose reduction.<br><br>1) Resident #17 had diagnoses including dementia with other behaviors, delusional disorders, and psychotic disorders with delusions with known physiological condition. The 9/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, was feeling down, depressed, or hopeless for several days, had no delusions, hallucinations, or behaviors, received antipsychotic medication, and did not receive antidepressant medications.<br><br>The Comprehensive Care Plan documented:<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - initiated on 9/21/2023 the resident had a psychosocial well-being problem related to dementia, and their mood was stable. Interventions included encourage participation from the resident who depended on others to make decisions; provide opportunities for the resident and family to participate in care.<br><br>- initiated on 12/18/2023 the resident used psychotropic medications related to depression and history of delusions related to dementia. Risperidone (antipsychotic) was discontinued on 12/22/2023 and Rexulti (antipsychotic) was started on 12/23/2023; Lexapro (antidepressant) was discontinued on 1/25/2024; and Seroquel was started on 10/15/2024. Interventions included to monitor for any adverse reactions to psychotropic medications and monitor and record occurrence as needed for any behavior symptoms and document per policy.<br><br>There was no documented evidence of a person centered care plan to address the resident's potential for behavioral symptoms related to their diagnosis of delusions and psychosis.<br><br>The June 2024 Behavior Monitor documented the resident had two episodes of yelling and screaming on 6/1/2024.<br><br>The 6/18/2024 Assistant Director of Nursing progress note documented the resident was discussed on medical rounds due to increased fatigue on Seroquel 25 milligrams twice a day. A new order was given for Seroquel 25 milligrams once a day. There was no documentation why the resident was receiving an antipsychotic.<br><br>The 6/2024 Medication Administration record documented 25 milligrams of Seroquel in the morning and at bedtime for anxiety with a start date of 6/13/2024. The order was discontinued on 6/18/2024 and the resident was started on 25 milligrams at bedtime for anxiety on 6/18/2024.<br><br>The 6/24/2024 social services note by Licensed Master Social Worker Consultant #40 documented they met with the resident for a supportive visit to address their increased anxiety. They attempted to obtain reason as to why the resident became more anxious. They discussed relaxation and breathing techniques during the visit. There was no documented evidence relaxation and breathing were included in the resident's care plan.<br><br>The 8/21/2024 pharmacy review documented the resident was receiving the antipsychotic agent Seroquel but lacked an allowable diagnosis to support its use. The pharmacy review listed appropriate diagnoses and conditions to which the provider had circled Mania, bipolar disorder, depression with psychotic features, treatment and signed 8/30/2024.<br><br>The 9/20/2024 pharmacy review documented the resident's diagnoses needed to be updated to reflect the diagnosis on the pharmacy recommendation from 8/2024.<br><br>A physician order dated 10/15/2024 documented Seroquel (an antipsychotic) 25 milligrams at bedtime for mania, bipolar depression with psychotic features.<br><br>There were no physician progress notes from 6/2024-11/15/2024 addressing the resident's need for an antipsychotic medication.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/18/2024 at 11:47 AM, Social Worker #27 stated they were unsure why Resident #17 was on Seroquel. They stated the diagnosis listed in the computer was for mania related to bipolar depression with psychotic features. They stated it may have been prescribed when the resident was in the community, but they had never seen the resident behave in an erratic way. The resident denied a history of depression and anxiety when they had asked the resident but when the resident gets upset about her physical condition, staff intervention helped. There were no major concerns with anxiety or behaviors that would need a care plan.<br><br>During an interview on 11/18/2024 at 1:59 PM, the Assistant Director of Nursing stated Resident #17 had episodes of anxiety. The resident did not have a lot of episodes, most of their anxiety was pain medication related. The resident had a history of depression and occasional delusions related to misidentification syndrome. They stated the resident did not recognize people by their face sometimes and only recognized names. They stated the resident changed from Risperdal to Rexulti in December 2023 due to being excessively sleepy and they were taken off the Rexulti in January 2024 due to falls. They stated they did not know why the provider chose Seroquel for the resident's anxiety. They stated the resident was started back on the antipsychotic for anxiety. They received phone calls from the resident two to three times a day, even at night, related to the resident wanting pain pills or a pill for oxygen.<br><br>During a telephone interview on 11/19/2024 at 10:49 AM, Physician #22 stated the pharmacy reviewed psychotropic medications quarterly and they reviewed the medications with nursing if there were changes in the resident's condition such as increased behaviors. They stated they renewed medications every 60 days. They stated Resident #17 had underlying dementia and had episodes of delusional thinking and fixed false beliefs. The resident had Capgras syndrome, where they believed someone was not who they said they were and had some psychotic features. The resident was on Seroquel for their fixed false beliefs and delusions related to their dementia. They were unaware of any diagnosis of bipolar disorder in the resident's medical history and did not recall why that was the diagnosis assigned to the Seroquel. They stated when the resident was off all psychotropic medication from January 2024 to June 2024, the resident had waxing and waning moments of delusions. They stated the resident had anxiety but was also a mixed clinical presentation of issues as the resident's fixed false beliefs drove their anxiety and that was part of their progressive dementia. They stated the resident should have had a behavioral modification care plan as that should be a part of everyone's plan of care.<br><br>2) Resident #62 had diagnoses including Huntington's disease (a genetic brain disorder causing nerve cells to break down and die), anxiety disorder, homicidal ideations, and violent behavior. The 8/12/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had fluctuating inattention and disorganized thinking, had no behaviors, required maximum assistance to dependence for most activities of daily living, received antipsychotic medication on a routine and as needed basis, a gradual dose reduction had not been attempted, and a gradual dose reduction was not documented by a physician as clinically contraindicated.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335475 | A. Building<br>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<br>New Hartford, NY 13413 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The undated Comprehensive Care Plan documented the resident had a behavior problem of agitation related to their diagnosis of Huntington's disease. The resident was accusatory toward staff related to sexually inappropriate comments regarding their spouse and false accusations of abuse. Interventions included administer medication as ordered, anticipate and meet the resident's needs, provide opportunity for positive interactions, discuss the resident's behavior with them if reasonable, explain all procedures for resident care prior to start, monitor behavior episodes and report any changes, praise improvement in behavior, report refusals of meals or fluids to charge nurse, serve the resident meals in hallway to prevent overstimulation and distress, and if the resident referenced self-harm and/or suicidal thoughts staff were to immediately notify social work, nursing, and the provider and implement suicide protocol safety precautions for a minimum of 30 days, until the resident's mood state was adequately re-assessed to ensure resident's safety. The resident utilized psychotropic medications related to behavior management due to the Huntington's Disease which included 2 milligrams of Haldol (an antipsychotic medication) either by mouth or by injection every 6 hours as needed. Interventions included to administer medications as ordered and to monitor for side effects and effectiveness.<br><br>The 8/8/2024 Physician #22 order documented the resident was to receive 2 milligrams of Haldol by mouth every 6 hours as needed for agitation. There was no end date on the medication.<br><br>Medication Administration Records documented Haldol oral tablet 2 milligrams by mouth every 6 hours as needed for agitation with a start date of 8/8/2024. There was no end date documented on the Medication Administration Records. The resident received 2 milligrams of Haldol as needed:<br><br>- nine times in August 2024 on 8/9/2024 at 8:57 PM, 8/12/2024 at 12:35 AM, 8/14/2024 at 7:36 PM, 8/15/2024 at 7:47 PM, 8/16/2024 at 8:03 PM, 8/22/2024 at 3:03 PM, 8/22/2024 at 3:04 PM, 8/26/2024 at 3:29 PM, and 8/30/2024 at 4:15 PM.<br><br>- five times in September 2024 on 9/4/2024 at 4:29 PM, 9/13/2024 at 7:52 PM, 9/14/2024 at 8:26 PM, 9/15/2024 at 9:48 AM, and 9/28/2024 at 12:29 PM<br><br>- three times in October 2024 on 10/5/2024 at 4:44 PM, 10/20/2024 at 12:05 PM, and 10/23/2024 at 3:50 PM.<br><br>- once in November 2024 from 11/1/2024-11/19/2024 on 11/14/2024 at 4:11 PM.<br><br>Nursing progress notes corresponding to Medication Administration for as needed Haldol documented:<br><br>- on 8/9/2024 at 8:57 PM by Licensed Practical Nurse #43the resident was yelling/screaming at their roommate and rolling themself onto the floor mat.<br><br>- on 8/12/2024 at 12:35 AM by Licensed Practical Nurse #44 the resident was agitating and screaming.<br><br>- on 8/14/2024 at 7:36 PM by Licensed Practical Nurse #43 the resident was anxious, agitated and yelling out.<br><br>- on 8/15/2024 at 7:47 PM by Licensed Practical Nurse #43 the resident was agitated/yelling at roommate, climbing onto mats at bedside.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 8/16/2024 at 8:03 PM by Licensed Practical Nurse #45 for agitation.<br><br>- on 8/22/2024 at 3:03 PM and 3:04 PM by Licensed Practical Nurse #43 for increased anxiety/agitation.<br><br>- on 8/26/2024 at 3:29 PM by Licensed Practical Nurse #43 for increased anxiety/agitation, yelling out for an alcoholic drink.<br><br>- on 8/30/2024 at 4:15 PM by Licensed Practical Nurse #43 for increased agitation/anxiety/yelling out.<br><br>- on 9/4/2024 at 4:29 PM by Licensed Practical Nurse #43 for increased anxiety/agitation/yelling/cursing loudly and rolling self off the bed onto mats.<br><br>- on 9/13/2024 at 7:52 PM by Licensed Practical Nurse #43 for agitation, screaming at staff, refusing shower and resistive/combative with care.<br><br>- on 9/14/2024 at 8:26 PM by Licensed Practical Nurse #46 for increased anxiety, heard calling staff inappropriate names and making accusations. The resident was unable to be redirected and continued to yell louder and more frequently.<br><br>- on 9/15/2024 at 9:48 AM by Licensed Practical Nurse #46 for continuously yelling out about lying, cheating spouse. Attempts to redirect and changing topic ineffective.<br><br>- on 9/28/2024 at 12:29 PM by Licensed Practical Nurse #46 no reason documented.<br><br>- on 10/5/2024 at 4:44 PM by Licensed Practical Nurse #46 crying out and yelling about their spouse. Asking where they went, attempted redirection and playing music with no success.<br><br>- on 10/20/2024 at 12:05 PM by Licensed Practical Nurse #47 verbal agitation toward staff, unable to redirect.<br><br>- on 10/23/2024 at 3:50 PM by Licensed Practical Nurse #43 for increased anxiety/agitation/cursing at staff.<br><br>- on 11/14/2024 at 4:11 PM no nursing note.<br><br>There was no documented evidence the use of the as needed Haldol was re-assessed every 14 days.<br><br>During an interview on 11/18/2024 at 1:22 PM, Licensed Practical Nurse #41 stated the providers did not enter medication orders into the system. They stated as needed psychotropics were entered in for a duration of 14 days then they were reviewed by the medical provider. After they were initially reviewed, they were unsure if a review had to be done every 14 days after that. They stated on 10/13/2024 Resident #62's as needed antipsychotic order was reviewed by Physician #23. When the order was entered after review, it should have had an end date of 14 days. They stated they had forgotten to make the end date 14 days. They stated the providers were in every week and as needed. The resident had delusions and yelled out but was easily redirected.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/18/2024 at 1:40 PM, Registered Nurse Unit Manager #17 stated non-pharmacological interventions were to be utilized prior to as needed psychotropic medications. They were unsure how often as needed psychotropic medications had to be reviewed. The as needed psychotropic medications were reviewed by Licensed Practical Nurse #41 when the providers rounded on the unit. Resident #62 had delusions, suicidal ideations, verbal abuse towards staff, and yelled but they were not a danger to themself or others. The as needed antipsychotic for Resident #62 should not have an indefinite end date. The order was non-compliant with the policy with having no end date.<br><br>During a telephone interview on 11/19/2024 at 10:50 AM, Physician #22 stated psychotropics were reviewed by pharmacy at least quarterly, with changes in condition, and when nursing requested due to increased behaviors. The Huntington's unit usually had a younger population that came in on psychotropic medication so there was no concrete answer. They stated as needed psychotropic medication was reviewed every 14 days, and the order should only be for 14 days. They were unaware of why Resident #62's as needed antipsychotic had an indefinite end date, and they also did not know why it was not caught previously. They stated the nursing staff put the orders into the electronic medical record after it was verbally given to them by the provider. The neurological unit was a specialized unit, and most residents needed an as needed psychotropic medication as they could be dangerous to themselves or others due to their diagnoses. The electronic medical record usually notified the nurses when a medication was due for a renewal, and they notified the provider. When prescribing or renewing a psychotropic as needed medication, they reviewed the symptoms and the frequency of the symptoms. Resident #62 showed behaviors in which an as needed Haldol order was necessary. The order, however, should have been put in per regulations to only be for 14 days and then reviewed every 14 days after that.<br><br>During a telephone interview on 11/19/2024 at 11:26 AM, Pharmacy Consultant #42 stated medication reviews were done monthly, which included as needed psychotropic medications. The as needed psychotropic medications must be renewed every 14 days. They stated they wrote a template for the provider and the provider signed it for a specific reason if the order was going to be renewed for another 14 days. On admission, the provider had not wanted to take any psychotropic medications away from the resident. During the resident's stay there were multiple notes about the resident's behaviors. The resident had Huntington's Disease and the Haldol was appropriate for their behaviors.<br><br>10 NYCRR 415.12(1)(2)(i) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>35045<br><br>Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not ensure that medications were secure and inaccessible to unauthorized staff and residents, for 1 of 1 resident (Resident #2) reviewed. Specifically, there was a medicine cup full of pills on Resident #2's tray table during breakfast.<br><br>Findings include:<br><br>The facility policy, Storage and Administration of Medications, revised 9/2024, documented medications were administered with a physician/nurse practitioner/physician assistant order and should be given by a licensed nurse. All medications should be maintained in a medication cart that can be locked. When administering oral medications to residents, the nurse should stay with the resident until they are sure the medication has been swallowed. Do not leave medication on a meal tray or bedside table to be taken at the resident's discretion.<br><br>Resident #2 had diagnoses including dementia, chronic kidney disease, and anxiety disorder. The 10/18/2024 Minimum Data Set assessment documented the resident had intact cognition, was independent with eating, and<br><br>took high-risk medications including antipsychotics, antidepressants, anticoagulants (blood thinners), diuretics (water pills), and opioids.<br><br>During an observation and interview on 11/13/2024 at 8:59 AM, Resident #2 was sitting up in bed eating breakfast. There was a plastic medicine cup containing multiple pills on the resident's tray table. The resident stated they were not sure what the pills were, they cannot take all the pills at once and the nurse leaves the pills on the table to take when they are done eating.<br><br>During an observation and interview on 11/13/2024 at 9:02 AM, Licensed Practical Nurse #10 stated they left the pills at Resident #2's bedside because there were so many, and the resident had taken several big potassium pills first. They left the cup of pills with the resident because the resident would take them after they ate their breakfast. They would keep checking on the resident to see how many were left until all the pills were taken. They stated they were unsure what all the pills were off the top of their head. The medication cup of pills was taken to the medication room and the nurse was able to verify and identify with the electronic record and blister packs all 21 pills which included:<br><br>- Namenda 10 milligrams, white pill with 172 imprinted and was for dementia.<br><br>- isosorbide 20 milligrams, 2 white round tablets used for their congestive heart failure.<br><br>- diltiazem HCL 180 milligrams, one big blue capsule used for hypertension.<br><br>- Cymbalta 20 milligrams, 1 brown capsule- used for depression<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - allopurinol 100 milligrams, 1 white circle pill with score, used to treat gout.<br><br>- metolazone 2.5 milligrams, 1 pink circle pill use to treat fluid overload with congestive heart failure.<br><br>- Multaq 400 milligrams, a white oblong pill inscribed with the number 4142 used to treat fluid overload.<br><br>- metoprolol 100 milligrams, 1 pink round pill used to treat hypertension.<br><br>- torsemide 20 milligrams, 4 white pills inscribed with PA 917, used to treat fluid overload.<br><br>- Eliquis 5 milligrams, one pink oblong pill used as a blood thinner, to prevent clotting.<br><br>- Protonix 40 milligrams, 1 oval shaped pill used to treat acid reflux.<br><br>- sertraline 50 milligrams, 1 and a half blue tablets used to treat depression.<br><br>- Tylenol 500 milligrams, 2 white tablets, to equal 1000 milligrams, used to treat pain.<br><br>- lactase oral tablet 9000 units, 1 oblong pill used for lactose intolerance.<br><br>- multivitamin, one red circle pill, for a nutritional supplement.<br><br>During an additional interview on 11/13/2024 at 9:51 AM, Licensed Practical Nurse #10 stated they updated the electronic record to reflect the time the medications were taken, had worked at the facility for a long time, received a medication competency, and knew they should not have left the medications at the resident's beside. It was unsafe as another resident could take them, or the resident's health could be affected in a negative way if not taking their medications on time. The resident received several medications for their heart and for hypertension.<br><br>During an interview on 11/15/2024 at 10:48 AM, Resident #2 stated they did not care when they took their medication but was unable to take all the medications at one time.<br><br>During an interview on 11/19/2024 at 11:58 AM, Registered Nurse Unit Manager #9 stated the medication nurse should never leave medication at a resident's beside or on the tray table unless there was an order for the resident to self-administer their medications. Resident #2 did not have an order to self-administer medications. They were not aware that the resident could not take all their medications at once. It was unsafe to leave medications with a resident that did not have an order to self-administer medications. The safety risk increased in the house where Resident #2 resided because they had the highest number of dementia residents there. There were a lot of residents that walked around, they could take the medications not prescribed for them and could get sick from taking them. It was a dangerous situation and was basic nursing practice to not leave medication at the bedside for the resident to take later.<br><br>10NYCRR 483.45 (g)(h) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33421<br><br>35045<br><br>46276<br><br>Based on observations and interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 2 meal trays tested (Rehabilitation Unit lunch) and beverages for the [NAME] house breakfast. Specifically, scrambled eggs, home-fried potatoes, toast, applesauce, mixed fruit, corn, milk, orange juice and cranberry juice were not served at palatable temperatures.<br><br>Findings include:<br><br>The facility policy, Meal Service, revised 1/2022, documented food was served in a manner to encourage consumption. Food was seasoned and not overcooked to conserve nutrients and flavor. Food was served at acceptable temperatures to prevent the potential of food-borne illness.<br><br>The facility policy, Temperature Control and Food Holding, revised 1/2023, documented food was maintained at proper temperatures during service to meet resident's expectations for palatability. Cold foods were refrigerated or held in ice and must be held at 40 degrees Fahrenheit or below. Hot foods must be cooked to reach internal temperatures based on food safety guidelines and temperatures must be taken just prior to service to ensure that holding temperatures of 135 degrees Fahrenheit were maintained. Food should be plated right before service to maintain proper temperature and palatability.<br><br>The 9/18/2024 Resident Council meeting minutes documented:<br><br>- two residents stated the food was cold and the vegetables were mushy.<br><br>- one resident stated the vegetables were undercooked.<br><br>Resident interviews included:<br><br>- on 11/12/2024 at 10:47 AM, Resident #140 stated the food temperatures were not good and the food did not taste good. Their family would often bring them in meals.<br><br>- on 11/12/2024 at 10:51 AM, Resident #63 stated the food was mushy, did not taste good, and was served cold.<br><br>- on 11/12/2024 at 11:04 AM, Resident #139 stated the food was often served late, did not taste good, and they were still hungry after meals.<br><br>- on 11/12/2024 at 1:58 PM, Resident #475 stated the food was always served cold.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - on 11/12/2024 at 2:15 PM, Resident #18 stated the food was served cold when it arrived to their room and it was bland tasting.<br><br>During an observation of the [NAME] House breakfast on 11/14/2024 at 8:14 AM there were three glasses of orange juice and four glasses of milk on the dining room table with no residents seated at the table. A glass of orange juice and one glass of milk were sampled for temperatures. The 4 ounce glass of orange juice was measured at 58 degrees Fahrenheit, and the 8 ounce glass of milk was measured at 58 degrees Fahrenheit.<br><br>During an interview on 11/14/2024 at 8:45 AM, Dietary Supervisor #33 stated breakfast service started at 7:30 AM. Drinks should be served when the residents arrived in the dining room and not placed on the table prior to their arrival. They were unsure why drinks were placed and left on the table early. The drinks should be below 40 degrees Fahrenheit. It was not acceptable for milk and orange juice to be 58 degrees Fahrenheit, and they should have been discarded. Dietary Supervisor #33 stated hot foods, such as the scrambled eggs and home-fried potatoes should be 165 degrees Fahrenheit. The measured temperatures of 98 degrees for eggs and 88 degrees Fahrenheit for home-fried potatoes were not acceptable and the residents could be at risk for food-borne illnesses. There was a log to record food temperatures prior to serving and they had not checked any food temperatures prior to serving that morning.<br><br>During an observation of the Rehabilitation Unit lunch on 11/14/2024 at 1:15 PM, Resident #18's lunch tray was served, and a replacement was requested. Temperatures were measured on the original lunch tray as follows: the applesauce was 65 degrees Fahrenheit; the corn was 130 degrees Fahrenheit; and the cranberry juice was 62 degrees Fahrenheit.<br><br>During an interview on 11/19/2024 at 11:17 AM, Operations Manager #15 stated cold food items should be served less than 40 degrees Fahrenheit, hot food items should be served above 145 degrees Fahrenheit, and holding temperatures should be 165 degrees Fahrenheit.<br><br>During an interview on 11/19/2024 at 11:28 AM, Food Service Director #14 stated cold food items should be served at 40 degrees Fahrenheit or less and hot food items should be served at 140 degrees Fahrenheit or more. The orange juice, milk, cranberry juice, and applesauce were not at acceptable temperatures. They stated it was important for hot foods to be served hot and cold food to be served cold to all residents.<br><br>10NYCRR 415.14(d)(1)(2)<br><br>48052<br><br>48675 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276<br><br>48675<br><br>Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024 - 11/19/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the facility's main kitchen and in 4 of 9 house kitchenettes (Magnolia, Cypress, [NAME], and Sycamore) reviewed. Specifically, the main kitchen had multiple unclean surfaces and undated food; and the Cypress, [NAME], Sycamore and Magnolia house kitchenettes had opened and undated food items.<br><br>Findings include:<br><br>The facility policy, Cleanliness and Sanitation, revised 3/2017, documented the following guidelines would be followed regarding cleanliness and sanitation of the kitchen equipment, food preparation, storage, dining, and wash areas:<br><br>- Pots and pans would be free of grease, smooth to touch, and clean with no buildup of debris.<br><br>- Walls, ceilings, doors, and floors would be free of dust, dirt, stains, spots, and debris.<br><br>- Refrigerator/Freezer walls, ceilings, and floors would be free of ice, drippings, debris, and the compressor units free of dust/dirt buildup.<br><br>- The underneath and exterior of the fryer would be free of oil, grease buildup, and dirt.<br><br>The following observations were made in the main kitchen:<br><br>- on 11/12/2024 at 10:18 AM, the dairy cooler floor was unclean with food debris.<br><br>- on 11/14/2024 at 11:37 AM, the walls behind and surrounding the dish machine were unclean with dark stains.<br><br>- on 11/15/2024 at 11:40 AM, the meat freezer had ice buildup on the floor and icicles on the ceiling. At 11:41 AM, the dairy freezer had a large block of ice on the lower right side of the compressor; at 11:47 AM, there was a metal scoop inside the dry flour container; and at 11:48 AM, the fryer had grease buildup on the left side, underneath, and inside the door and there was food debris on the floor underneath the fryer; and at 11:54 AM, a frying pan on the clean rack had dried thick, black debris on the base of the handle, inside, and underneath the pan.<br><br>During an observation on 11/15/2024 at 10:43 AM, the Magnolia house kitchenette freezer had opened and undated plastic bags of frozen chicken breasts, hamburgers, hot dogs, and English muffins. There was ice buildup on the frozen meat inside the bags.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335475 | A. Building<br>B. Wing | 11/19/2024 |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 11/15/2024 at 1:45 PM, the Cypress house kitchenette refrigerator had an undated plastic container of green beans.<br><br>During an observation on 11/15/2024 at 2:10 PM, the [NAME] house kitchenette freezer had undated frozen hamburgers.<br><br>During an observation on 11/15/2024 at 2:35 PM, the Sycamore house kitchenette cabinets had two opened and undated 5-pound containers of peanut butter.<br><br>During an interview on 11/15/2024 at 10:45 AM, Food Service Worker #28 stated they worked in the Magnolia house for 7 years. The frozen food was used for resident's who wanted an alternative meal. The food would come frozen in a large box to the Aspen house, and they would take some of the frozen food to their house and put it in the freezer. They stated there were dates on the large boxes of frozen food and they did not put dates on the food they put in their freezer because they would know when the food went bad and had to be thrown out.<br><br>During an interview on 11/19/2024 at 11:07 AM, Operations Manager #15 stated they had food labels, and all food items should be dated. After 3 days food was to be discarded and if food was not dated it should be discarded immediately. Frozen food items had to be dated and as long as they stayed frozen, they did not have to be discarded unless there was an expiration date on the box. All items in the freezer should be kept in a sealed bag or container, and if it was not appropriately sealed or dated it should not be given to any resident. They stated the kitchen was cleaned daily. Staff was supposed to clean their work area as they went, and the entire kitchen was cleaned at night before staff left. The fryer was supposed to be wiped down and cleaned every time it was used and if kitchen staff noticed it was dirty they were expected to clean it even if it was not being used. The walk-in coolers and freezers were cleaned weekly and included sweeping, mopping, wiping down shelves, walls, and ceilings. There should never be ice buildup inside the freezers or on the compressor because people could slip, or the compressor could stop working properly and contaminate the food or make it go bad. They stated the scoopers should never be left inside the dry food bins because bacteria could grow. The frying pans were used daily so they were checked frequently, and they should not have any black buildup or dried debris on them because it could cause an infection control issue or get into the resident's food.<br><br>During an interview on 11/19/2024 at 11:23 AM, Food Service Director #14 stated all food items in the refrigerator or freezer must be dated. Cold food items should be discarded after 3 days and if there was no date it should be discarded immediately. All opened frozen food items should be kept in an airtight container, be dated, and if not used in 2 weeks should be discarded. The main kitchen was cleaned twice a day and staff were expected to keep their work area clean during their shift. At night, all kitchen staff were responsible for cleaning which included mopping and sweeping. There should not be any grease buildup or splatter on or around the fryer and it was supposed to be wiped down after each use. Coolers and freezers were cleaned daily which included sweeping, wiping down the walls and shelves, and checking food dates. The freezers were defrosted once a month by maintenance and should not have any ice buildup inside or on the compressor. The ice could be a safety issue causing people to slip or the compressor might not function properly. Scoopers should not be left in the dried food bins because it could cause cross contamination. Pans should not be used if there was any buildup or dried debris on them because it could get into the resident's food.<br><br>10NYCRR 415.14(h) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>33421<br><br>48675<br><br>Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024-11/19/2024, 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 4 residents (Resident #17 and #475) reviewed. Specifically, Certified Nurse Aide #31 did not use appropriate personal protective equipment when providing care to Resident #475 who was on transmission based precautions (enhanced barrier precautions); and Resident #17 had an order for transmission based precautions (contact precautions) and did not have those precautions in place.<br><br>Findings include:<br><br>The facility policy, Contact Precautions, revised 3/2022, documented contact precautions were used in addition to standard precautions in instances when disease was spread by direct or indirect contact. A physician's order would be placed in the electronic record for contact precautions, an isolation sign would be posted outside the resident's room, and gloves and a gown would be worn when anticipating direct contact with the resident.<br><br>The facility policy, Enhanced Barrier Precautions, revised 9/2024 documented the utilization of enhanced barrier precautions was an infection control intervention designed to reduce transmission of multidrug resistant organisms (bacteria resistant to antibiotics). Enhanced barrier precautions were used in conjunction with standard precautions and expanded the use of personal protective equipment by using a gown and gloves during high contact resident care activities.<br><br>1) Resident #475 had diagnoses including surgical aftercare following surgery on the circulatory system and benign prostatic hyperplasia with lower urinary tract symptoms (enlarged gland that can cause urinary difficulty). The 11/11/2024 Minimum Data Set assessment documented the resident was cognitively intact, occasionally incontinent of urine, had a surgical wound, did not have an indwelling urinary catheter (a tube that drains urine from the bladder), and did not have multidrug-resistant organisms.<br><br>The Comprehensive Care Plan initiated 11/5/2024, documented the resident had impairment to skin integrity of the neck related to a surgical wound. Interventions included enhanced barrier precautions. The revised 11/11/2024 care plan documented the resident had an indwelling catheter related to urinary retention. Interventions included enhanced barrier precautions.<br><br>The 11/11/2024 physician order documented the resident was on enhanced barrier precautions every shift.<br><br>The 11/11/2024 Physician #22 progress note documented the resident was seen for urinary retention and a urinary catheter was in place draining yellow urine.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 11/14/2024 at 9:28 AM, Resident #475 activated their call light. Certified Nurse Aide #31 walked to the resident's doorway. There was an enhanced barrier precautions sign outside the room and a 3-drawer plastic bin full of personal protective equipment. The resident stated they needed assistance to use the bathroom. Certified Nurse Aide #31 put on gloves and entered the room without putting on a gown. At 9:35 AM, Certified Nurse Aide #31 exited the room without a gown or gloves and walked down the hall to the sink to wash their hands. They stated they were not available for an interview at that time and had to finish helping other residents.<br><br>During an interview on 11/14/2024 at 11:50 AM, Certified Nurse Aide #31 stated when a resident was placed on precautions a sign was hung outside their room to alert staff, and personal protective equipment was placed outside their room. Resident #475 was on enhanced barrier precautions, and they thought the resident had something like an infection that could have been spread to others. They were supposed to wear a gown and gloves when they provided direct care, but they did not wear a gown when they assisted the resident to the toilet because they got busy and forgot to put one on. They stated they had received education on transmission based precautions and knew it was important to wear a gown when providing care to prevent the spread of infection to themself and other residents.<br><br>During an interview on 11/18/2024 at 12:30 PM, Licensed Practical Nurse #35 stated residents that had open wounds, catheters, or central lines were put on enhanced barrier precautions. Once they were placed on precautions a sign was hung on their doorframe and personal protective equipment was placed outside their room. All staff received infection control training and learned about the different precautions and what personal protective equipment was needed when providing care. Resident #475 was on enhanced barrier precautions and staff had to wear gloves and a gown when preforming hands on care. They stated it was important to wear the appropriate personal protective equipment to prevent the spread of infection to residents or staff.<br><br>During an interview on 11/18/2024 at 12:40 PM, Registered Nurse Unit Manager #13 stated enhanced barrier precautions was required for any resident who had an open wound, central line, or catheter. Staff were required to wear a gown and gloves when performing resident care. They stated all nursing staff received training on all transmission based precautions annually and it was important for them to wear the appropriate personal protective equipment to protect the residents and staff from spreading or getting an infection.<br><br>During an interview on 11/19/2024 at 11:45 AM, Assistant Director of Nursing/Infection Preventionist #36 stated residents with wounds, central lines, catheters, and pressure ulcers were put on enhanced barrier precautions. All nursing staff received education on precautions. They stated they completed random audits on personal protective equipment usage. If Resident #475 was on enhanced barrier precautions, it was important for staff to wear a gown during care to prevent the spread of infection and cross contamination.<br><br>2) Resident #17 had diagnoses which included methicillin-resistant staphylococcus aureus infection (a bacterium with antibiotic resistance) in an unspecified site, dementia with other behavioral disturbance, and chronic congestive heart failure. The 9/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, utilized a walker and a wheelchair, was dependent with putting on and taking off footwear, required maximum assistance for lower body dressing, required supervision for transfers, did not have multidrug-resistant organisms, had an active diagnosis of methicillin-resistant staphylococcus aureus infection, and was not on an antibiotic.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Comprehensive Care Plan revised 9/4/2024 documented the resident had Methicillin-resistant Staphylococcus aureus in their right great toe. Interventions included the resident was on contact isolation, the staff were to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard, bag linens and close bag tightly before taking to laundry, the resident's family and caregivers were to be educated regarding the importance of hand washing, using antibacterial soap, disposable towels, and to wash their hands immediately after activities of daily living, care tasks, and activities, and for the resident to be given antibiotic therapy as ordered.<br><br>The 7/7/2024 physician order documented the resident was on contact precautions due to Methicillin-resistant Staphylococcus aureus in their right great toe.<br><br>A 7/9/2024 at 12:41 PM Physician #22 progress note documented the resident was being treated for an infected paronychia (nail infection) which was growing Methicillin-resistant Staphylococcus aureus and was on doxycycline (antibiotic).<br><br>The November 2024 Treatment Administration Record documented the resident was on contact precautions for Methicillin-resistant Staphylococcus aureus of the right great toe with a start date of 7/7/2024. The Treatment Administration Record was signed as acknowledged 11/1/2024-11/15/2024 (missing 11/15/2024 day signature).<br><br>The following observations of Resident #17 were made:<br><br>- on 11/12/2024 at 10:35 AM, their room had no signs indicating they were on contact precautions and there was no personal protective equipment available outside the resident's room.<br><br>- on 11/13/2024 at 8:54 AM, there were no contact precaution signs on the resident's room door and no personal protective equipment cart or table outside the resident's door.<br><br>- on 11/14/2024 at 8:26 AM, there were no contact precaution signs outside the resident's room door or a personal protective equipment table or cart. Licensed Practical Nurse #37 left resident's room and an unidentified dietary aide walked into the resident's room without wearing any personal protective equipment. At 11:17 AM and 2:26 PM, there were no contact precaution signs outside the resident's door and there was no personal protective equipment readily available outside the resident's room.<br><br>- on 11/15/2024 at 9:24 AM, 11:25 AM, and 1:14 PM, there were no precaution signs outside the resident's room door and no personal protective equipment table or cart immediately available outside the resident's room.<br><br>A 11/15/2024 at 2:08 PM Physician #22 progress note documented the resident had right toe paronychia with Methicillin-resistant Staphylococcus aureus and was being treated with doxycycline.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/15/2024 at 1:17 PM, Certified Nurse Aide #38 stated they knew a resident was on transmission-based precautions and which kind of precautions based on the sign posted outside their room and through verbal report given to them. They knew what personal protective equipment to wear into a transmission-based precaution room by the items set up on the table or in the cart next to the entrance to the resident's room. They stated they currently had no residents in the house on contact precautions. They stated Resident #17 was not on contact precautions as far as they knew. They stated the resident had been on precautions a while back but was not anymore. They stated unless there was a sign posted outside of the resident's room, they only utilized standard precautions.<br><br>During an interview on 11/15/2024 at 1:23 PM, Licensed Practical Nurse #37 stated they knew a resident was on precautions as there was an order in the computer and there were transmission-based precautions signs outside the resident's room. They stated they knew which transmission-based precaution a resident was on by the infection control book that was at the nurses' station, and it was also listed on the resident's task sheets in the task binder. They stated there were also signs outside the resident's room to identify the type of precautions as well. They knew what personal protective equipment to wear into the resident's room as it was displayed outside the resident's room. They stated unless there was a sign outside a resident's room, they only used standard precautions for a resident. They stated this floor did not have any residents on contact precautions. Resident #17 had a swab for their toe recently as the resident previously had Methicillin-resistant Staphylococcus Aureus, but they did not have the results back. They stated Resident #17 did have a current order for contact precautions related to the previous Methicillin-resistant Staphylococcus aureus infection in their toe. Since it was an active order, the resident should be on contact precautions but when they inquired with their supervisor, they were told not to put the resident on precautions just in case their newest swab came back negative. Since the resident was not on precautions, they should not have been signing for the contact precautions in the record.<br><br>During an interview on 11/15/2024 1:32 PM, the Assistant Director of Nursing stated transmission-based precautions were determined by a lab test or an exposure to something infectious. There was also enhanced barrier precautions which a resident went on if they any access points where they could get an infection from staff, like a catheter or pressure injuries. They stated Resident #17's test results came back, and the resident had tested positive for Methicillin-resistant Staphylococcus Aureus so they should be placed on precautions. They were unaware the resident had an active order for precautions since 7/7/2024. They stated if a resident had an active order, the resident should have been on contact precautions. The order must not have been discontinued when they were previously able to come off precautions. They stated the nurses should not have been signing off the resident was on contact precautions if they were not.<br><br>10NYCRR 415.19(a)(b) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675<br><br>Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024-11/19/2024, the facility did not ensure there was an effective pest control program for the main kitchen, the neurology unit, Corridors 1 and 2, [NAME] house, and Sequoia house. Specifically, fruit flies, drain flies and an unknown insect were observed in the main kitchen, the neurology unit, Corridors 1 and 2, and [NAME] house. Additionally, resident family members complained of seeing mice in the Sequoia house.<br><br>Findings include:<br><br>The facility policy, Pest Control, last revised 7/2024, documented there was a system in place for staff to report any findings of a rodent or infestation of insects within or near the buildings as well as to ensure that preventative routine pest maintenance was in existence with an outside contractor. The pest control vendor was contracted with the facility to provide monthly service for pest control. The Director of Facilities or Housekeeping Manager were responsible to accompany the vendor on their rounds throughout the buildings and campus to review and sightings/findings that have been submitted in the work order system since previous date of service.<br><br>The 2024 pest control vendor treatments documented dates of service as 1/25/2024, 2/7/2024, 3/28/2024, 4/25/2024, 5/31/2024, 6/10/2024, 6/26/2024, 7//29/2024, 8/30/2024, and 10/7/2024. The vendor addressed mice, ants, bees including yellow jackets nests, and small drain flies. The vendor made recommendations including installing proper fitting door sweeps, adjusting doors to be rodent proof by properly sealing, sealing gaps in the walls in the kitchen pantries, fixing water leaks in various kitchens, and cleaning kitchen grease traps with proper biodegrade.<br><br>The following observations were made:<br><br>- on 11/12/22024 at 11:00 AM, there were 8 drain flies in the corridor 1 and corridor 2 shower room; at 11:22 AM, there was 1 fruit fly in the neurology unit kitchenette; at 11:24 AM there were 5 fruit flies in the neurology unit dining room near the kitchenette; at 11:45 AM there were 3 fruit flies in the neurology unit shower room [ROOM NUMBER]; and at 12:05 PM there was 1 fruit fly in the neurology unit shower room [ROOM NUMBER].<br><br>- on 11/14/2024 at 11:45 AM, there was 1 fruit fly in the main kitchen<br><br>- on 11/15/2024 at 11:54 AM, there were several fruit flies around the dish machine area in the main kitchen; at 2:20 PM, there was 1 unidentified insect crawling inside the kitchen cabinet near the [NAME] unit stove.<br><br>During an interview on 11/12/2024 at 3:00 PM, Resident #78's family member stated there were mice in the Sequoia house. The facility used mouse traps and the white sticky strips, but they were useless. They had seen baby mice and an adult mouse. They kept Resident #78's personal belongings in plastic containers so the mice could not get to them.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 11/19/2024 at 10:34 AM, the Director of Facilities stated they oversaw maintenance and housekeeping, and this included pest control. They stated they did not typically review the monthly logs unless staff brought up an issue. It was the Housekeeping Manager's responsibility, but they were no longer employed at the facility. They had just brought the logs to their office to review them. They had issues with mice, and they had pest control come in and address the issue. The staff had smart phones; this is how the work order system worked. The work orders stayed open until the pest control vendor came and addressed them. The mouse traps were checked monthly by the vendor. The drains were checked as needed, they did not have a schedule, and they were checked only when they were alerted to an issue. Pest control was important for sanitary reasons.<br><br>10 NYCRR: 415.29(j)(5) |