STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335482	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood at Ticonderoga	101 Adirondack Drive Ticonderoga, NY 12883

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during an abbreviated survey (Case #2577186), the facility did not ensure they immediately consulted with the resident's physician when there was a significant change in condition for one (1) (Residents #1) of one (1) resident reviewed for significant changes. Specifically, for Resident #1 the physician was not notified that the resident had pulled out the urinary catheter. This is evidenced by:The Facility's Policy and Procedure titled, Change in Resident Condition Assessment, last modified 4/12/2018, documented; A change of condition is defined as a major change in the resident's status that: 1. Is not self-limiting. 2. Impacts one or more areas of health status. 3. Requires review/revision of the care plan. The procedure staff were to follow was documented as: 1. The change of condition is documented in the resident's medical record. 2. The physician will be contacted to determine the need for medical intervention.Resident #1 was admitted to the facility with diagnoses of acute pyelonephritis (kidney infection), multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and chronic kidney disease stage four (4). The Minimum Data Set (an assessment tool) dated 6/12/2025, documented the resident could be understood, could understand others and had moderately impaired cognition for decisions of daily living.A Nursing Progress note dated 6/29/2025 at 4:05 AM documented the resident had been awake all night and staff found them with catheter pulled out and blood was noted on the bedding.The resident's medical records did not have documented evidence that the physician was notified of the catheter removal.A Comprehensive Care Plan Titled: Indwelling Urinary Catheter, initiated 6/11/2025, documented the medical provider was to be updated as needed.During interview on 8/05/2025 at 10:30 AM, Administrator #1 and Director of Nursing #1 stated the resident was only here for a short time and was sent to the hospital following a rapid decline. The resident's family was with them when this occurred and requested, they be sent to the hospital despite the do not hospitalize wishes of the resident. They did not recall the resident having pulled out the urinary catheter. Director of Nursing #1 stated ‘that did not sound like something that resident would have done.'During interview on 8/05/2025 at 12:30 PM, Director of Nursing #1 stated the nurse that was assigned to the resident at the time of the incident no longer worked there and there was no documentation that a medical provider was notified when the resident pulled out the catheter causing a change in condition. They stated the on-call provider service was contacted to see if they had been called by the nurse on 6/29/2025 but were unable to provide the information.During an interview on 8/05/2025 at 2:21 PM, Registered Nurse #1 stated that they assumed care of the resident in the afternoon after the facility changed assignments around due to staffing issues. They stated that the resident pulled their Foley catheter out earlier in the day and was urinating in the brief throughout the day. They were not aware if the Physician was notified. During interview on 8/05/2025 at 2:36 PM, Licensed Practical Nurse #1 stated the resident was up and appeared fine during the day shift on 6/29/2025. The resident had no complaints and was urinating in the briefs. Licensed Practical Nurse #1 was told by night nurse the catheter was not being replaced because there was no order, and they thought it should not be replaced due to the trauma caused by resident pulling it out with balloon inflated. They stated they were not aware the physician was not called. They would have called the on-call provider if resident had pulled the catheter out on their shift.Registered Nurse #4 was the nurse responsible for the care of Resident #1 at the time of the incident. On 8/05 2025 at 1:50 PM and 8/06/2025 at 11:50 AM, attempts to contact Registered Nurse #4 were unsuccessful.On 8/05/2025 at 3:52 PM, attempt to contact Medical Provider #1 was unsuccessful. 10 New York Codes Rule Regulations 415.3(e)(2)(ii)(b)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and interviews conducted during an abbreviated survey (Case #2577186), the facility did not ensure that a resident with an indwelling catheter, received the appropriate care and services in accordance with professional standards of practice. Specifically, there was no documented evidence that resident's catheter care was provided. This is evidenced by:A review of facility policies documents that the facility had policies for insertion of an indwelling catheter for male patients last modified on 1/23/2028, removal of supra-pubic or indwelling catheter last revised on 4/11/2028, and the daily care of an indwelling catheter last modified on 11/22/2023. The policies did not address unintended removal of a catheter. Resident #1 was admitted to the facility with diagnoses of acute pyelonephritis (kidney infection), multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and chronic kidney disease stage four (4). The Minimum Data Set (, an assessment tool) dated, 6/12/2025 documented the resident could be understood, could understand others and had moderately impaired cognition for decisions of daily living. Resident #1 was admitted to the facility with a Foley catheter.Review of Physician orders did not indicate any orders for the appropriate care for the resident's Foley catheter.Review of the resident's Comprehensive Care Plan documented that the resident had an indwelling Foley catheter due to urinary retention and acute pyelonephritis (kidney infection). Interventions included providing catheter care daily and as needed, updating the medical director or nurse practitioner of the resident's status as needed, and monitoring and documenting urinary output and urine characteristics (i.e. color, odor, consistency).Review of nursing progress notes on 6/29/2025 documented that the resident self-removed their Foley catheter with balloon inflated. The resident was found at 4:05 AM by Registered Nurse #4 sitting on the edge of their bed with blood on the bedding. The facility physician was not notified about the resident's situation, and the resident was eventually transferred to the hospital.During an interview on 8/05/2025 at 12:30 PM, Director of Nursing #1stated that the nurse who was there at the time of the incident no longer worked at the facility, and there was no documentation that a medical provider was notified when the resident had a change in condition and pulled out their catheter. There should have been orders for daily care, routine changing and replacement of the catheter. There were no complaints or grievances from the resident or family during their stay. Director of Nursing #1 stated they did not see that the resident's urine output was monitored after the catheter was pulled out, which was not documented. They stated that the resident's catheter was not replaced because the resident was on a comfort measure-only order. Director of Nursing #1 stated that nurses follow physician orders. If there was no order, then the provider should be called for any issue not addressed by the physician. They stated that since the resident was admitted with an indwelling urinary catheter, there should have been an order from the physician.Attempt to interview Registered Nurse #4 on 8/05/2025 at 1:52 PM were unsuccessful.During an interview on 8/05/2025 at 2:21 PM, Registered Nurse #1 stated that they assumed care of the resident in the afternoon after the facility changed assignments around due to staffing issues. They stated that the resident pulled their foley catheter out earlier in the day. They stated that there was no order for the foley catheter and therefore did not replace it. They stated that the only time they called a physician was when the resident was sent to the hospital. They stated that they would monitor the resident for the need to replace based on bladder scans and the ability to urinate.During an interview on 8/05/2025 at 2:36 PM, Licensed Practical Nurse #1 stated that they were the nurse taking care of the resident on 6/29/2025. They stated that they came into work that day at 6:10 AM and were not told that the resident pulled their foley catheter out, and they read it on the 24-hour report that is used for daily reporting of the unit. They stated that the resident did not complain of any discomfort throughout the day. Licensed Practical Nurse #1 stated that in any case that a resident pulled their Foley catheter out, staff should follow the physician's orders. They stated that if there were no orders, staff should be contact a physician and following their directions. They stated that they did not call the physician that day as the resident was not complaining of any discomfort.During an interview on 8/05/2025 at 3:36 PM, Licensed Practical Nurse #1 stated that residents with foley catheters had orders for routine care of the residents' indwelling catheter. They stated that the routine care of residents with indwelling catheters included cleaning the area of insertion of the catheter, making sure that the catheter is intact, and recording the color, consistency, and amount of urine. Licensed Practical Nurse #1 reviewed the residents' electronic chart and stated there were no orders from the physician for the residents' indwelling catheter.Attempt to interview Medical Provider #1 were unsuccessful. 10 New York Codes and Rules and Regulations 415.12