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	07/15/2024

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

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35228 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure the resident had a right to be treated with respect and dignity, including: The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 (Resident #47) of 4 residents reviewed for restraints. Specifically, Resident #47 had a chair alarm (a pad placed on a chair) hooked to a sensor box that alarmed if a resident attempted to stand) on their wheelchair to alert staff if they attempted to stand up. This is evidenced by: Resident #47 was admitted to the facility with diagnoses of dementia with mood disturbance, a stroke (a medical condition in which poor blood flow to the brain causes cell death), and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 7/04/2024, documented the resident had severe cognitive impairment, could be understood, and could understand others. The Minimum Data Set, dated dated dated [DATE], documented in the restraint assessment section that an alarm was any physical or electronic device the monitored resident movement and alerted the staff when movement was detected. It documented the resident did not have a chair alarm. The Policy and Procedure titled, Physical Restraints Policy last modified on 5/24/2018, documented a resident had to right to be free from physical restraints for the purposes of discipline or convenience, and for purposes not required to treat the resident's medical condition or symptoms. It documented an interdisciplinary physical assessment was to be initiated by the Unit Manager/Social Worker/Designee when a long-term care resident was utilizing a physical restraint. On 7/09/2024 at 11:30 AM, a chair alarm was observed on the back of the resident's wheelchair. On 7/10/2024 at 11:38 AM, a chair alarm was observed on the back of the resident's wheelchair. The document titled, Physical Restraint/Device Decision Tree Evaluation dated 5/18/2024 at 3:04 AM, documented the resident did not have a physical device or equipment that may potentially restrict a resident's movement and/or access to their body. The Comprehensive Care Plan had no documentation the resident had a chair alarm in use. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Certified Nurse Aide care plan as of 7/10/2024 did not document the resident had a chair alarm. The Medical Doctor orders were reviewed. There was no order for a chair alarm. During an interview on 7/12/2024 at 12:18 PM, Licensed Practical Nurse Unit Manager #3 stated a restraint assessment should be completed before using a chair alarm. They stated Resident #47 was not supposed to have a chair alarm. During an interview on 7/15/2024 at 3:06 PM, Director of Nursing #1 stated the facility used chair alarms. They stated it was an intervention used to keep residents from falling out of their wheelchairs. Director of Nursing #1 stated a restraint assessment was not done for the use of a chair alarm because it was not considered a restraint. 10 New York Codes, Rules, and Regulations 415.4(a)(2-7)

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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 0656 Level of Harm - Minimal harm or potential for actual harm 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. 35228 Based on observations, record review, and interviews, during a recertification survey, the facility did not ensure it developed and implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights for 1 (Resident #47) of 20 residents reviewed for comprehensive care plans. Specifically, Resident #47 did not have a comprehensive care plan for the chair alarm (a pad placed on a chair that is hooked to a sensor box). It alarmed if a resident attempted to stand) on their wheelchair to alert staff if they attempted to stand up. This is evidenced by: Resident #47 was admitted to the facility with diagnoses of dementia with mood disturbance, a stroke, and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 7/04/2024, documented the resident had severe cognitive impairment, could be understood, and could understand others. The Policy and Procedure titled, Care Planning (Interdisciplinary Team) last modified on 01/22/2019, documented the interdisciplinary team would develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that included measurable objective and timeframe to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. On 7/09/2024 at 11:30 AM, a chair alarm was observed on the back of the resident's wheelchair. On 7/10/2024 at 11:38 AM, a chair alarm was observed on the back of the resident's wheelchair. The Comprehensive Care Plan had no documentation the resident had a chair alarm in use. The Certified Nurse Aide care plan as of 7/10/2024 did not document the resident had a chair alarm. During an interview on 7/15/2024 at 3:06 PM, Director of Nursing #1 stated facility used chair alarms as an intervention to keep residents from falling out of their wheelchairs. Director of Nursing #1 stated if a resident had a chair alarm it should be documented on their care plan. 10 New York Codes, Rules, and Regulations 415.11(c)(1)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that it provided, based on the comprehensive assessment, care plan, and the preferences of each resident, an ongoing activities program to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 (Resident #'s 10 and 24) of 3 residents reviewed for activities. Specifically, Resident #'s 10 and 24 were not provided with activities on an ongoing basis according to the residents' Comprehensive Care Plan and activities provided did not meet the residents' preferences. This is evidenced by: A facility policy titled Activity Program Content and Planning dated 7/23/2018 and last revised 7/12/2018, documented that the Director of Activities would establish a plan for a leisure-time activities program for residents of the facility to include individual and group programs seven days a week at various times of the day and evening. To meet these programming requirements the Director of Activities would plan leisure activities classified as follows: One to One Programming, Person Appropriate, combinations of large and small group activities which would promote a resident's sense of usefulness to self and others, make daily living more meaningful, enjoyable, and stimulate and support the resident. Resident #10 Resident #10 was admitted with diagnoses of unspecified dementia severe with agitation, anorexia (an eating disorder causing food avoidance), and failure to thrive (inability to care for oneself). The Minimum Data Set (an assessment tool) dated 5/01/2024, documented the resident had significant cognitive impairment, sometimes understood, and could sometimes understand others. The Comprehensive Care Plan for Activities initiated 12/14/2018 and last revised on 4/29/2024, documented the resident had potential for alteration in activities related to their diagnoses. No goals were listed. Interventions included: Resident would attend Mass and Related Services. The Comprehensive Care Plan for Activities: Leisure initiated 8/08/2019 and last revised on 3/04/2024, documented the resident had potential barriers related to leisure activities of choice related to cognition, social skills, endurance, mobility, fear, range of motion limitations, hearing deficits, visual acuity, communication, pain, and general weakness. Goals included address cognitive engagement, physical activity tailored to the resident's physical state, social activities, and attendance. Interventions listed included attending programs through invitation, programs involving coloring and drawing, Bingo, exercise, going outdoors, Rummy, music, pet visits, reading and writing, social activities, and parties, conversing with peers, family or staff, individual visits with staff, pets and volunteers, and sensory programs like aromatherapy and massage. During an observation on the Adirondack unit on 7/08/2024 from 11:30 AM to 1:30 PM, Resident #10 was observed to be sitting in their wheelchair at a table, alone. The resident was served lunch at the same table during lunch time. Staff were observed interacting with the resident only during the passing of the lunch trays. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on Adirondack unit on 7/09/2024 from 8:45 AM to 11:00 AM, Resident #10 was again observed sitting by themselves, and was served lunch alone at a table. During an observation on Adirondack unit on 7/10/2024 from 8:15 AM to 11:30 AM, Resident #10 was observed sleeping in their wheelchair in front of the television in the main common room on the unit. Resident #10 was woken for lunch and taken to the main dining room off the unit. There were no activities offered to Resident #10 during these observations. Record Review of the Activity Log for Resident #10 for May 2024 provided documentation of between 1 and 3 activities daily. Documentation showed Resident #10's participation level varied between active and passive participation. The activity log for May 2024 documented the following: On 5/05/2024, the activity log documented Resident #10 received a total of 14 minutes of activities that day. On 5/16/2024, the activity log Resident #10 received a total of 9 minutes of activities. On 5/19/2024 the activity log documented Resident #10 received 23 minutes of activities. On 5/27/2024, the activity log documented Resident #10 did not participate in any activities for the day. Review of the activity log for May 2024 revealed no documentation of activities for the following dates: 5/04/2024, 5/06/2024, 5/12/2024, 5/13/2024,5/15/2024, 5/17/2024, 5/18/2024, 5/20/2024, 5/25/2024, and 5/26/2024. Resident #24 Resident #24 was admitted with diagnoses of Parkinson's disease with dyskinesia (a neurological disorder causing involuntary movements), dementia, major depressive disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively impaired, could be understood, and understand others. The Comprehensive Care Plan for Activities initiated 4/27/2018 and last revised on 5/28/2024, documented the resident had potential for alteration in activities related to their diagnoses. Goals listed included interacting with family and friends, attending, and actively participating in facility like and activity programs. Interventions included: environmental modifications such as positioning resident near staff, reminding resident when activities were taking place, and attending religious services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for Activities: Leisure initiated 9/09/2019 and last revised on 12/07/2023, documented the resident had potential barriers related to leisure activities of choice related to cognition, mobility, communication, pain, and general weakness. Goals included addressed cognitive engagement, motivation, perception, visual acuity, physical activity tailored to the resident's physical state, social activities, and attendance. Interventions listed included attending programs through invitation, programs involving coloring and drawing, Bingo, exercise, cooking programs, crafting, gardening, going outdoors, Rummy, music, pet visits, reading and writing, social activities, and parties, conversing with peers, family or staff, individual visits with staff, pets and volunteers, and sensory programs like aromatherapy and massage. Record review of the Activity Log for Resident #24 for May 2024 provided documentation of between 1 and 5 activities daily. Documentation showed Resident #24's participation level varied between active, passive, and refused participation. The activity log for May 2024 documented the following: On 5/16/2024, the activity log documented Resident #24 received a total of 26 minutes of activities. On 5/19/2024 the activity log documented no activities for Resident #24. On 5/26/2024 the activity log documented no activities for Resident #24. On 5/27/2024, the activity log documented Resident #24 received a total of 27 minutes of activities. Review of the activity log for May 2024 revealed no documentation of activities for the following dates: 5/17/2024 and 5/25/2024. Record review of the one- to one participation summary provided by the facility from May 2024 through July 2024 documented the resident received one to one visit on 5/02/2024, 5/20/2024, 5/22/2024, 5/23/2024, 5/29/2024, 6/01/2024, 6/20/2024, 6/26/2024, and 7/11/2024. During an observation on Adirondack Unit on 7/08/2024 from 11:30 AM to 1:30 PM, Resident #24 was observed sitting in their wheelchair at a table, sometimes with another resident, or sometimes by themselves. The resident was served lunch at the same table during that time. Staff were observed interacting with the resident only during the passing of the lunch trays. No activities were observed being done on Adirondack Unit where Resident #24's resided. However, in the main dining room, off the unit, activities were observed on and off all day for residents brought to the main room, or residents that were able to self-propel themselves to the activity area. During an observation on Adirondack Unit on 7/09/2024 from 8:45 AM to 11:00 AM, , Resident #24 was again observed sitting by themselves, and was served lunch alone at a table. No activities were observed being done on Resident #24's unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on Adirondack Unit on 7/10/2024 Resident #24's from 8:15 AM to 11:30 AM, Resident #24 was observed sitting alone at a table in the common room on the unit. No activities were observed being done on the unit. However, in the main dining room, off the unit, activities were observed on and off all day for residents brought to the main room, or residents that were able to self-propel themselves to the activity area. The staff were observed interacting with the resident while they fed the resident lunch. During an interview on 7/09/2024 at 9:24 AM, Resident #24 stated they would like to do more activities. They stated they understood that due to their physical state, going places was limited, however they would enjoy more interaction. Resident #24 stated they had to yell to get the staff to pay attention to them when they were placed in the main common area. Resident #24 stated their family had also asked the facility to provide the resident with more activities. During an interview on 7/11/2024 at 12:17 PM, Certified Nurse Aide #4 stated residents were offered drinks and smoothies when the activities person came around with a beverage cart. During an interview on 7/11/2024 at 12:22 PM, when asked what kind of activities were offered to residents, Licensed Practical Nurse #1 stated that activities person came every day with a smoothie cart and flavored water. Snacks could be requested and sometimes they offered to residents who were nonverbal. During an interview on 7/12/2024 at 10:15 AM, Activities Director #1 stated they tracked resident's activities through a system that documented participation. Normally the large dining room was used for the participants from the Patriot Unit and at the same time, the same program would be run on the Adirondack Unit by another staff member in the main area or in the ancillary rooms off the back of the unit. Activities Director #1 stated the person who ran the Adirondack Unit activities left with minimal notice and had not yet replaced. The loss of that staff member made running dual activities at the same time impossible to do. Activities Director #1 stated they run a report every 7 days to find out which residents were not participating in activities and sets up one -on ones within a week's time. One on one visits were documented in the Electronic Medical Record. Residents who just liked to talk were supposed to be given one-on-one visits. New admissions were given about a month to settle in before they were approached with activities. If the resident had been resistant to activities in the past, they were given some room to decide what they would like to do. If possible, they tried to keep the person assigned to resident for one-on-one visits or have developed good rapport with a resident so there would be continuity of care. The staff helped set up zoom and facetime calls with family if the resident's family could not come to see them. There have been some volunteers that came in. Religious leaders also came to the facility to do services, Jehovah Witnesses came and did bible study, people with service animals including dogs, a rabbit, a turtle, and a donkey came to visit the residents. 10 New York Code of Rules and Regulations 415.5(f)(1)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47140 Based on observation, record review, and interviews during a recertification survey, the facility did not ensure the provision of nutritional and hydration care and services to each resident, consistent with the resident's comprehensive assessment, therapeutic diet, and preferences for 4 (Residents #3, #23, #24 and #63) of 5 residents reviewed. Specifically, Residents #3, #23, and #63 were not monitored for weight loss, assessed when significant weight loss occurred, and did not receive correct meals consistent with physician ordered diets and recommendations for meal/caloric intake. Additionally, Residents #24 and #63 were not monitored for dehydration and beverages were not offered throughout the day. This is evidenced by: Cross-referenced to F805: Food in Form to Meet Individual Needs and F804: Nutritive Value/Appearance/Palatability The facility policy, Nutrition and Hydration Needs, last revised 7/19/2018, documented the Registered Dietitian or Diet Technician would assess the nutritional needs of each resident upon admission and as needed. Factors used to estimate needs included but were not limited to the resident's diagnosis, comorbidities, lab values, and skin status. The facility policy, Intake and Output-Monitoring, initiated 1/30/2018 and last revised 8/31/2018, documented that all residents were offered sufficient fluid intake to maintain proper hydration and health, additional fluids were offered throughout the day, every resident would be monitored daily to identify clinical conditions that placed them at risk for dehydration, and hydration guidelines would be considered based on clinical judgement. Clinical conditions that placed residents at risk for dehydration included but were not limited to decrease in typical fluid consumption, hot weather, compromised skin integrity, dehydration, and others. The facility policy, Nutrition and Hydration Needs, initiated 7/19/2018 and modified on 7/19/2018, documented estimated fluid needs were based on weight and a minimum of 1500 milliliters per day. 1) Resident #3 had diagnoses including dysphagia-oropharyngeal phase (difficulty swallowing), chronic kidney disease, and need for assistance with personal care. The Minimum Data Set (an assessment tool) dated 5/22/2024, documented the resident had moderate cognitive impairment for decisions of daily living, could be understood, and could understand others. The Comprehensive Care Plan dated 1/26/2022, documented the resident had an alteration/potential for alteration to their nutrition related to a history of weight fluctuation, was at risk for weight loss due to medical diagnoses including dysphagia. The resident had a potential for alteration to their oral/dental status related to the use of dentures and tendency to keep food in their mouth when eating or taking medications, related to dysphagia. Interventions included provide the resident's diet as ordered and modify their meal consistency as necessary and per physician orders. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #3's Nutritional Assessment completed on 5/30/2024 documented the resident was at nutritional risk related to low body mass index (measure of body fat based on height and weight, healthy weight is 18. 5-24.9). At the time, the resident had relatively good acceptance of offered supplements with a goal of adequate intake of food and fluid and to have no signs or symptoms of significant weight loss. The nutrition recommendation/plan was to provide the resident with their diet as ordered and monitor the need for changes in dietary regimen. Resident #3's Weight Record documented they were weighed monthly. Weights were documented as: - March 2024 90.5 pounds - April 2024 89.6 pounds - May 2024 88.5 pounds - June 2024 87.5 pounds - July 2024 84.4 pounds (6.7 % weight loss in 3 months) During an interview on 7/10/2024 at 10:55 AM, Registered Dietitian #1 stated they were a part-time employee between two different facilities. They had not received a report or information on residents who were at risk for weight loss from the previous Registered Dietitian. The Director of Dietary Services monitored residents' weight loss in the building and alerted them of residents who were losing weight. They had not seen or assessed Resident #3 yet and was not alerted to the resident's weight loss. They accessed the Electronic Medical Record used by the facility and noted the resident's weight was trending down over six months. They stated that adjusting supplements may be a recommendation they made for a resident's weight trending down. They still needed to learn what the facility did to implement additional interventions when a resident was losing weight. During an observation and interview on 7/10/2024 at 12:16 PM, Resident #3 was eating their lunch meal in the dining room of the care unit. The resident stated their meal tasted terrible. The resident's meal ticket documented their diet consistency as easy to chew. The resident's meal included baked ham which was cut in inconsistent shapes and sizes and had a skin/thicker outer layer. The baked dinner roll had varying textures with the exterior being hard/crispy and the interior being soft. Resident #3 stated their meal had been cut up by nursing staff. Resident #3 was seated across from Resident #38 who had the same diet consistency. Resident #38's meal had ham that was cubed into equal sizes, approximately one inch by one inch, with a sauce to moisten the ham. Registered Dietitian #1 was present in the dining room and observed the two trays and noted the differences between the two meal trays with the same ordered diet. Registered Dietitian #1 stated Resident #3's meal was not correct for the ordered consistency. They stated the skin/ outer layer on the ham could present a choking risk. Registered Dietitian #1 offered to have Resident #3's meal brought to the kitchen to be corrected, however, Resident #3 stated they could do it themselves and proceeded to tear the ham into smaller pieces with their fingers and pick at their food. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) Resident #23 had diagnoses including dysphagia-oropharyngeal phase (difficulty swallowing), iron deficiency anemia, and chronic obstructive pulmonary disease (lung disease). The Minimum Data Set, dated dated dated [DATE], documented the resident had intact cognition, was understood, and could understand others. The Minimum Data Set documented resident was on mechanically altered diet. The Comprehensive Care Plan dated 4/21/2023, documented the resident had had an alteration/potential for alteration to their nutrition related to weight loss and diagnoses which included iron deficiency, sepsis (system wide infection), chronic obstructive pulmonary disease, anemia, and dysphagia (difficulty swallowing) and was ordered a mechanically altered diet consistency. Interventions included the resident's dietary preferences should be determined with substitutions offered as needed, the resident's diet be provided as ordered, and provide Magic Cup (nutritional supplement) and 4 ounces of cottage cheese with meals. Resident #23 Weight Record documented the following monthly weights: - March 2024, 109 pounds -April 2024, 105 pounds -May 2024, 105 pounds -June 2024, 103 pounds -July 2024, 91.4 pounds (a 16% weight loss in 4 months) A 6/13/2024 Director Dietary Services #1 Weight Warning progress note documented Resident #23 continued to gradually lose weight over the previous month. Supplements were adjusted the previous month from Boost Breeze (nutritional supplement) to Boost Plus, but the resident stated they did not like the supplements and was not going to consume them. Traditional food options available were reviewed with the resident to increase calories and protein. The resident liked cottage cheese, cheese slices, hard boiled eggs, egg salad, and tuna salad. The resident liked milk (not chocolate) and enjoyed chocolate ice cream. Magic Cups (nutritional supplement) were to be offered and cottage cheese was added to lunch and dinner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observations and interview on 7/08/2024 at 12:06 PM, Resident #23 was served their lunch meal tray by Certified Nurse Aide #5 in their room. The resident's meal ticket documented the resident required a mechanical soft ground diet and should be served cottage cheese. The resident's ordered a mashed sweet potato without skin included and mixed vegetables that should be soft (able to be easily mashed). The resident did not receive cottage cheese with their meal and was served instant mashed potato (not sweet potato) and green beans. The resident stated they were often served meals that were not correct, incomplete or of a consistency that they could safely eat, and they had lost a lot of weight because of it. The resident stated they were supposed to receive cottage cheese with their meals and that their family had bought cottage cheese and placed it in the resident refrigerator on the unit to ensure that they received it even if the facility did not have it. The resident stated they had lost so much weight that they had boney prominences in their back, buttocks and hips that caused them pain and need for frequent repositioning. The resident stated the vegetables they were served were often undercooked/too hard for them to chew. The resident then placed the green beans on the tray and used their fork to demonstrate that the green beans were undercooked and were too tough. The resident stated that they only could use their upper denture and their lower denture no longer fit them due to significant weight loss. The resident was not provided with a magic cup (nutritional supplement). Resident #23 pointed to their ticket and showed Certified Nurse Aide #5 that their meal order was not correct. Certified Nurse Aide #5 offered to take away the items that the resident stated they could not/would not eat but did not offer an alternative. When asked about the meal ticket, Certified Nurse Aide #5 stated they could check with the kitchen to see if they had cottage cheese to provide. During an observation and interview on 7/09/2024 at 12:07 PM, Resident #23 was served their lunch meal tray. The resident's meal ticket documented the resident's diet texture should be soft, and bite sized. The resident's meal order included beef stew at ordered thickness with moistened, bite sized noodles and soft bite sized carrots. The resident took a bite of the beef stew and then spit a chunk of meat back onto the tray. The piece of meat was approximately two inches by one inch in size. The resident pulled out another piece of meat which had a thick band of gristle (cartilage) and was observed to be tough and not bite sized. The resident stated they could not eat the stew or the carrots and demonstrated that the carrots were undercooked by trying to mash them and being unable to. The resident's meal tray did not include cottage cheese, or a magic cup (nutritional supplement). Registered Nurse #1 came to the resident's room and observed the meal and stated they did not think the meal was proper consistency and should be sent back to the kitchen. Registered Nurse #1 removed the resident's meal tray and offered the resident a sandwich as an alternative which the resident agreed to. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/10/2024 at 10:55 AM, Registered Dietitian #1 stated that since they started at the facility three weeks prior, they had not yet run a weight report to look at residents for weight loss and weight fluctuations. They stated they did not receive any information from the former Registered Dietitian when they started. They stated the Registered Dietitian should be the one to review meal intake documentation, weight fluctuations, those triggered for weight loss and evaluate interventions. They stated there was a lot of residents at the facility who had difficulties with chewing and swallowing. They stated they had not seen/assessed Resident #23 since they started working at the facility. They then reviewed the Electronic Medical Record/facility's dietary system and noted that the resident had had significant weight loss. Based on the record, they stated that the resident did not like some of the supplements that had been offered but they did like cottage cheese, hard boiled eggs and chocolate magic cup. They stated cottage cheese should be served to the resident during lunch and dinner and the resident should be served a magic cup with their breakfast, lunch and dinner. They stated the resident received liquiCell (supplement for wound healing) during medication pass. They stated residents with wounds had increased nutrient needs. During an interview on 7/15/2024 at 1:05 PM, Director of Nursing #1 stated the Director of Dietary Services #1 monitored residents for weight loss and would report to the Registered Dietitian. They stated they did not know whether nursing or dietary staff would then report weight loss to the physician. They stated residents with significant weight loss would be discussed in daily huddles. They stated the Registered Dietitian would evaluate the resident's nutrition and set up interventions/appropriate supplements to target weight loss. They stated that residents should receive complete, accurate meals in order to meet their nutritional needs. 3) Resident #24 was admitted with diagnoses of Parkinson's disease with dyskinesia (a neurological disorder causing involuntary movements), dementia, and major depressive disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and understand others. The Comprehensive Care Plan titled Nutrition dated 5/14/2018, documented the resident needed to be encouraged to intake adequate fluids, use of adaptive equipment to prevent spilling for all fluids, and monitoring signs of dehydration such as poor skin turgor, dry skin, or confusion. During an observation on Adirondack Unit on 7/08/2024 from 11:30 AM to 1:30 PM, Resident #24 was observed sitting in their wheelchair at a table, periodically an independently mobile resident would sit with Resident #24. The resident was served lunch at the same table during that time. Staff were observed interacting with the resident only during the passing of the lunch trays. The resident was not observed to have a drink expect during meals. No staff were observed offering beverages in between meals. During an observation on Adirondack Unit on 7/09/2024 from 8:45 AM to 11:00 AM, Resident #24 was again observed sitting by themselves, and was served lunch alone at a table. No drinks were observed to be near the resident except during mealtimes and no staff were observed offering Resident #24 a drink between meals. During an observation on Adirondack Unit on 7/10/2024 from 8:15 AM to 11:30 AM, Resident #24 was observed sitting alone at a table in the common room on the unit. Resident was not observed with beverages except during mealtimes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/09/2024 at 9:24 AM, Resident #24 stated they would like to do more activities. Resident #24 also stated that they had to yell to get the staff to pay attention to them when they were placed in the main common area, which they found to be upsetting. Resident #24's tongue was observed to be dry and have ridges during the interview. No drinks were noted to be on the table for Resident #24 to enjoy between meals. During an interview on 7/11/2024 at 10:55 AM Registered Dietitian #1 stated there was a hydration protocol for people with hydration issues. They did not know if hydration protocol was applicable to everyone in the building. When asked what they would do if they noticed hydration issues, like a ridged tongue, Registered Dietitian #1 stated they would mention it to the Medical Doctor based on intakes and outputs. They stated they relied on staff to tell them about physical signs of dehydration issues. Registered Dietitian #1 stated that they were the corporate dietitian and that their time worked was split between multiple buildings. They stated both the Activities Director and the Director of Food Service would reached out when there were issues. During an interview on 7/11/2024 at 12:17 PM, Certified Nurse Aide #4 stated residents were offered drinks and smoothies when the activities person came around with a beverage cart in the afternoon. During an interview on 7/11/2024 at 12:22 PM, Licensed Practical Nurse #1 stated that activities person would come every day with a smoothie cart and flavored water. Snacks could be requested and sometimes they were offered especially if the resident was nonverbal. During an interview on 7/15/2024 at 11:15 AM, Director of Nursing #1 stated that it was the expectation that staff provided drinks and refreshments throughout the day. Drinks were provided by the unit clerks and activities staff. It was expected that residents would be rounded on every couple of hours. 10 New York Codes, Rules, and Regulations 415.12(i)(1) 48744 50996

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48744 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not provide pharmaceutical services including procedures that assured the accurate dispensing and administering of all drugs and biologicals according to professional standards for 1 (Resident #21) of 11 residents reviewed. Specifically, Resident #21 was observed being administered a controlled substance which was not signed out on the controlled Drug and the medication was documented as administered on the Medication Administration Record. This is evidenced by: The facility ' s Medication Administration Policy and Procedure effective 1/25/2024, documented under Administration of Controlled Substances section, the registered nurse/licensed practical nurse would sign for the needed dose for the resident on the Controlled Drug Receipt record. Additionally, under Administration of Controlled Substances, Prior to administration, the amount to be administered would be recorded on the Controlled Substance Inventory Record and the Medication administration would be recorded on the Medication Administration Record/Electronic Medication Administration Record after administration. During an observation on 7/12/2024 at 11:42 AM, Registered Nurse #4 withdrew a narcotic medication, clonazepam 0.5 milligram tablet, from the medication blister pack and administered the medication to Resident #21. Registered Nurse #4 did not document the medication given on the narcotic inventory sheet. Registered Nurse #4 was observed removing the resident information from the newly empty blister pack medication card and disposed of the rest in the garbage. During an interview on 7/12/2024 at 11:42 AM, Registered Nurse #4 stated they intended to document the medication in the narcotic book and inventory sheet eventually. They also stated they knew they were supposed to do it when the medications were given, however, they usually wait until they have free time and do bunches of narcotic documentation at one time. Registered Nurse #4 stated they were being lazy and that they did the same thing that morning and had already put those medication passes into the narcotic book and on the inventory sheets. During an interview on 7/15/2024 at 10:45 AM, Registered Nurse Supervisor #1 stated it was the expectation that when a narcotic was given, the staff member would document the medication given at the time it was given. Additionally, staff should not be wait to the end of their shift or when they have free time to document medication passes or narcotics. Registered Nurse Supervisor #1 stated they were aware of the narcotic that was given out without being signed out and the staff member that did it. They stated they had done a mini education already with the staff regarding documentation of medications given and that staff should be dating and initialing the medication pill sheets as well in case something distracts the staff member. That way the staff could go back and see the documentation that something was given, and they could put it in the book if for some reason they got sidetracked before it could be entered. It was not the expectation nor was it good practice to hold off signing out narcotics until later. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/15/2024 at 11:15 AM, Director of Nursing #1 stated it was expected staff would document narcotic administration in the Electronic Medical Record and narcotic book at the time of administration. The narcotic count should be done at every shift change, and it was never appropriate to delay documenting a given narcotic until later in the shift. 10 New York Codes, Rules and Regulations 415.18 (b)(1)(2)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice in 1 of 2 medication carts reviewed for medication storage. This is evidenced by: The facility policy Medication Administration Methods, dated [DATE] documented medication expiration dates should be checked prior to administration. No facility policy was provided regarding the requirements for labeling insulin pens with the observed sticker showing the date opened and date of expiration. During an observation of the Patriot Unit medication cart on [DATE] at 11:33 AM with Licensed Practical Nurse #3, there was 1 opened Basaglar (glargine, long-acting insulin) Kwik insulin pen with a sticker documenting the date opened without the expiration date filled out. During an interview on [DATE] at 11:33 AM, Licensed Practical Nurse #4 stated the person who opened the Basaglar Kwik insulin pen should have labeled the sticker with both the date it was opened and the date it expired. Licensed Practical Nurse #4 stated the sticker on the insulin pen, with just the opened date and not the expiration date was incorrect, and a new one should be obtained from pharmacy. During an interview on [DATE] at 10:45 AM, Registered Nurse Supervisor #1 stated they expected when an insulin pen was opened for the first time, a sticker should be placed on the pen and include the date it was opened and the date it expired. During an interview on [DATE] at 11:15 AM, Director of Nursing #1 stated when opening insulin pens, they should include the opened date and the expiration date. 10 New York Codes, Rules and Regulations 415.18(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 43805 Based on record review, observation, and interview during the recertification survey, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 test trays (the 7/09/2024 and 7/10/2024 lunch meals) reviewed. Specifically, food and beverages served to residents for the 7/09/2024 and 7/10/2024 lunch meals on the Adirondack and Patriot main Dining Room were not palatable. Additionally, multiple residents complained of food palatability during the monthly facility Food Forum meetings. This was evidenced by: Food Forum Meeting documentation included the following concerns: - On 5/06/2024 all residents in attendance stated the soups lacked consistency. Some items such as rice, pork chops, and chicken were dry. One unnamed individual stated their hamburger was served on bread instead of a hamburger bun. - On 6/03/2024 residents requested more robust tastes, more gravy made available, and butter served with rolls, biscuits, and rice. During an observation on the Patriot main Dining Room on 7/09/2024 at 12:30 PM, the food arrived in steam tables and service to residents began immediately. The test tray was provided at 12:42 PM, and included beef baked stew and carrots. The beef baked stew did not appear appetizing, a large chunk of beef was difficult to chew and tasted gristly and tough, and the sauce was bland. The carrots tasted bland and unseasoned. During an observation on the Patriot main Dining Room on 7/10/2024 at 12:45 PM, the food arrived in steam tables and service to residents began immediately. The test tray was provided at 12:52 PM, and included a slice of herb roasted turkey, gravy, corn bread sausage stuffing, and green beans. The herb roasted turkey was bland, the gravy tasted very salty, the sausage in the corn bread stuffing was hard, the pepper in the stuffing was overcooked, the stuffing tasted bland, and the green beans were bland and overcooked Resident interviews included: -on 7/08/2024 at 11:37 AM, Resident #49 stated the food was not good. - on 7/08/2024 at 1:09 PM, Resident #15 stated the facility changed their menus about six months ago and the food had not been good since the change. - on 7/09/2024 at 9:28 AM, Resident #27 stated that the breakfast meal was good, but the rest of the meals were not. - on 7/09/2024 at 12:29 PM, Resident #54 stated the sausage was hard. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council meeting on 7/09/2024 at 1:52 PM, residents stated the meat served at lunch on 7/09/2024 was hard to chew. The meals in general were salty and did not appear appetizing on the plate. The residents stated the food did not taste like it should have tasted. During an interview on 7/11/2024 at 11:02 AM, Registered Dietitian #1 stated they planned to meet with each resident to go over food preferences. They stated they were new to the position and had not had the opportunity to talk to every resident yet. They were unaware of any food complaints. During an interview on 7/11/2024 at 12:37 PM, Director of Dietary Services #1 stated they were aware of the food complaints brought up in the Food Forum meeting. The facility had switched vendors, and the facility was working with new menus. During an interview on 7/12/2024 at 11:30 AM, Administrator #1 stated there was a Food Forum held separately from the resident council where residents could provide feedback on the meals. 10 New York Codes, Rules, and Regulations 415.14 (d)(1)(2) 48744

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47140 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure food was prepared in a form designed to meet the individual needs for 5 of 5 residents (Residents #3, #10, #23, #35, and #48) reviewed for diet consistency. Specifically, the Resident #3, #10, #23, #35, and #48 received meals that were not consistent with their physician ordered diets. This is evidenced by: Cross-referenced to F692: Nutrition/Hydration The facility policy, Nutrition and Hydration Needs, last revised 7/19/2018, documented the Registered Dietitian or Diet Technician would assess the nutritional needs of each resident upon admission and as needed. Factors used to estimate needs included but were not limited to the resident ' s diagnosis, comorbidities, lab values and skin status. The facility ' s Diet Manual, reviewed 5/14/2024, documented in accordance with the International Dysphagia Diet Standardization Initiative (IDDSI), diet consistency which was ordered as easy to chew included foods that were soft/tender in texture and diet consistency ordered as soft and bite sized included meats and other foods diced into half inch pieces or altered to make the food easier to chew and swallow. 1) Resident #3 had diagnoses including dysphagia-oropharyngeal phase (difficulty swallowing), chronic kidney disease, and need for assistance with personal care. The Minimum Data Set (an assessment tool) dated 5/22/2024, documented the resident had moderate cognitive impairment, could be understood, and could understand others. The Comprehensive Care Plan 1/26/2022, documented the resident had an alteration/potential for alteration to their nutrition related to a history of weight fluctuation, and was at risk for weight loss due to medical diagnosis including dysphagia. The resident had a potential for alteration to their oral/dental status related to the use of dentures and tendency to keep food in their mouth when eating or taking medications related to dysphagia. Interventions included to provide the resident ' s diet as ordered and to modify their meal consistency as necessary per physician orders. Resident #3 ' s physician ' s diet order dated 7/08/2024 documented regular diet easy to chew texture. A 7/03/2024 Speech Language Pathologist #1 progress note documented the facility would be transitioning to IDDSI (International Dysphagia Diet Standardization Initiative) diets. The resident was recommended to stay on a regular diet with easy to chew consistency with thin liquids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 7/10/2024 at 12:18 PM, Resident #3 was served their lunch meal in the dining room of the care unit. The resident ' s meal ticket documented the resident ' s diet consistency as easy to chew. The resident ' s meal included baked ham cut into inconsistent shapes and sizes, and the ham had a skin/thicker outer layer. A baked dinner roll had varying textures. The exterior of the roll was hard/crispy, and the interior was soft. The resident stated their meal was cut up by nursing staff. The resident was seated across from another resident who had the same diet consistency ordered, however, their meal had ham that was cubed into approximately one-inch by one-inch consistent size pieces with a sauce that moistened the ham. Registered Dietitian #1 was in the dining room and noted the differences between the two meal trays having the same ordered diet consistency. Registered Dietitian #1 stated that Resident #3 ' s meal was not correct for the ordered consistency. The skin/ outer layer that was left on the ham could present a choking risk to Resident #3. Registered Dietitian #1 offered to have Resident #3 ' s meal brought to the kitchen to be corrected, however, Resident #3 stated they could do it themselves and proceeded to tear the ham into smaller pieces with their fingers. 2) Resident #23 had diagnoses including dysphagia-oropharyngeal phase (difficulty swallowing), iron deficiency anemia, and chronic obstructive pulmonary disease (lung disease). The Minimum Data Set assessment dated [DATE], documented the resident had intact cognition. The Minimum Data Set documented resident was on mechanically altered diet. The Comprehensive Care Plan dated 4/21/2023, documented the resident had an alteration/potential for alteration in nutrition related to weight loss and diagnoses which included iron deficiency, sepsis (system wide infection), chronic obstructive pulmonary disease, anemia, and dysphagia. The resident received a mechanically altered diet consistency. Interventions included the resident ' s dietary preferences should be determined, and substitutions offered as needed, the resident ' s diet was provided as ordered, provide Magic Cup (nutritional supplement) and 4 ounces of cottage cheese with meals. During an observations and interview on 7/08/2024 at 12:06 PM, Resident #23 was served their lunch meal tray by Certified Nurse Aide #5. The resident ' s meal ticket documented the resident was on a mechanical soft, ground diet and should be served cottage cheese daily. The resident ordered a mashed sweet potato, without skin included, and mixed vegetables that should be soft (able to be easily mashed). The resident did not receive cottage cheese with their meal and was served instant mashed potatoes (not sweet potato) and green beans. The resident stated they were often served meals that were not the consistency they could safely eat or meals that were incomplete and they had lost a lot of weight because of it. They stated they had been served meal items on many occasions which they needed to spit back out or that caused them to cough/choke. The resident stated the vegetables they were served were often undercooked/too hard for them to chew. The resident then placed the green beans on the tray and used their fork to demonstrate that the green beans were undercooked and were too tough. Resident #23 pointed to their ticket and showed Certified Nurse Aide #5 that their meal order was not correct. Certified Nurse Aide #5 offered to take away the items that the resident stated they could not eat. The Certified Nurse Aide did not offer an alternative. Certified Nurse Aide #5 stated they would check with the kitchen to see if they had cottage cheese for the resident. (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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 7/09/2024 at 12:07 PM, Resident #23 was served their lunch meal tray. The resident ' s meal ticket documented the resident ' s diet texture as soft, and bite sized. The resident ' s meal order included beef stew with moistened, bite sized noodles, and soft bite sized carrots. The resident took a bite of the beef stew and spit a chunk of meat back onto the tray. The piece of meat was approximately two inches by one inch in size. The resident pulled out another piece of meat which had a thick band of gristle and was not bite sized. The resident said they could not eat the stew or the carrots and demonstrated the carrots were undercooked by trying to mash them and was unable to. The resident stated they had been served soup for dinner the night before that was too salty with undercooked vegetables, and they could not eat it due to the consistency. Registered Nurse #1 came to the resident ' s room and observed the meal and stated they did think the meal was the proper consistency and should be sent back to the kitchen. Registered Nurse #1 removed the resident ' s tray and offered them the alternative of a sandwich which the resident agreed to. During an observation and interview on 7/09/2024 at 12:51 PM, Speech Language Pathologist #1 observed the meal tray that was served to Resident #23 and stated the meat in the stew was larger than half-inch pieces the resident should have been served and could present a risk for choking/aspiration. They noted the thickness/gristle of some of the meat in the stew as a potential hazard to the resident. They tried to mash the carrots and stated the consistency was not soft and could not be easily mashed. All staff in the facility had received training on diet consistencies. They stated that all meals should be prepared per physician orders by the kitchen staff. Nursing staff were trained to recognize the correct diet consistencies and should bring meals back to the kitchen to be corrected if they noticed that a resident was served a meal that was not consistent with their ordered diet. The facility had changed their system to International Dysphagia Diet Standardization Initiative (IDDSI) that day and the language of meal consistencies in diet orders had changed so residents that were previously ordered a mechanical soft diet were now ordered to receive meals that were soft, and bite sized or easy to chew. During an observation and interview on 7/09/2024 at 1:20 PM, Director of Dietary Services #1 observed the meal tray that was served to Resident #23 and stated the meat in the stew was larger than the half-inch size that was required for residents with modified diet consistencies. The carrots should be soft and easily mashed with a fork. They stated the carrots served to Resident #23 were not soft enough and were undercooked. The kitchen staff should be checking to ensure the meals served were the correct size and consistency for residents who required modified diet consistencies. 3) Resident #48 had diagnoses including dementia, dysphagia (difficulty swallowing), and cognitive communication deficit. The Minimum Data Set assessment dated [DATE], documented the resident had severe cognitive impairment, could usually be understood, and could usually understand others. The Minimum Data Set documented resident was on mechanically altered diet. The undated Comprehensive Care Plan documented the resident had had an alteration/potential for alteration to their nutrition and required a mechanically altered diet. Interventions included the resident should be served their diet as ordered. (continued on next page)

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	07/15/2024

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A 5/20/2024 Speech Language Pathologist #1 progress note documented the facility and all facilities owned by the company would be transitioned to International Dysphagia Diet Standardization Initiative (IDDSI) diets. Resident #48 was on and tolerating a mechanical soft diet which would translate to a soft and bite sized in the International Dysphagia Diet Standardization Initiative (IDDSI). Due to the resident ' s age and cognitive status, soft and bite sized foods without bread was recommended. A 6/30/2024 Speech Language Pathologist #1 progress note documented they met with the resident ' s family and discussed transition to the International Dysphagia Diet Standardization Initiative (IDDSI) diets. They explained all diet textures offered with the International Dysphagia Diet Standardization Initiative (IDDSI) and reviewed the resident ' s strengths and weaknesses with swallow function. The resident ' s family explained the importance of food as comfort and pleasure for the resident throughout their life, and requested the resident be placed on an easy to chew diet consistency when the IDDSI diet plan was rolled out at the facility, and consider downgrade to soft bite sized if the resident demonstrated difficulty with the easy to chew diet. During an observation and interview on 7/10/2024 at 12:20 PM, Resident #48 was served their lunch meal in the dining room. The resident received slabs of whole turkey meat with gravy and a whole dinner roll. The resident picked up the roll, bit one section, and used their hand and arm strength to tear away a large piece of the roll. The roll had mixed textures with a hard outer layer and was soft inside. Certified Nurse Aide #3 cut the resident ' s turkey into pieces. Certified Nurse Aide #3 stated that meals served to residents who required modified diets should have the consistency modified by the kitchen staff. The resident should be served easy to chew meals with bite size pieces. During an interview on 7/10/2024 at 10:55 AM, Registered Dietitian #1 stated Resident #48 had a significant change related to nutritional intake. The resident should receive meals that were easy to chew and were not hard or have any gristle. They stated residents should be evaluated for particular food items they enjoyed determining if those particular items could be tolerated and were safe for them to eat. Any specific items the resident was assessed to be safe with should be added to the meal ticket. Modification for altered meal consistencies should also be completed in the kitchen. All staff at the facility had received training to recognize what food consistencies should look like and to return the meal tray if the meal served was not consistent with the ordered diet. They stated items that were considered easy to chew should be bite sized and easy to cut (with no sawing motion required). They stated that bread should be soft and not of mixed consistency. 10 New York Codes Rules and Regulations 415.14(d)(3) 48744