

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Bethel Nursing Home Company Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 17 Narragansett Avenue Ossining, NY 10562	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255</b></p> <p>Based on observation, interview, and record review, during the recertification survey from 3/18/25 to 3/21/25 the facility did not ensure that the call bell system was accessible for 1 (Resident #16) of 35 residents reviewed for Environment. Specifically, the facility did not ensure that Resident's #16 call bell was within reach.</p> <p>Findings include:</p> <p>The Policy and Procedure titled Call Bells dated 6/16/03 documented it is the policy of the facility that each resident has a call bell at bedside within reach. The cord should be clipped to the bed. The Nursing Assistant assigned to the resident must check for malfunction of call bells on each shift and report such to the nurse in charge.</p> <p>Resident #16 had diagnoses including depression, diabetes mellitus, and chronic obstructive pulmonary disease.</p> <p>The Minimum Data Set Quarterly assessment dated [DATE] documented the resident was cognitively intact. The resident required substantial assistance with roll left to right, and lying to sitting on side of bed; and was dependent on staff for toileting hygiene, and chair to bed and toilet transfers.</p> <p>The Comprehensive Care Plan for Fall-resident at risk for fall, last updated on 8/2/24, documented to ensure that call bell is within reach at all times and encourage the resident to call for assistance as needed.</p> <p>During observations on 3/18/25 at 9:54 AM, on 3/19/25 at 9:46 AM and on 3/20/25 at 9:27 AM Resident #16 was lying in bed on their back. The call bell was on the floor next to the wall and out of the resident's reach. The resident stated that they used the call bell to call for assistance but could not find it. The resident stated that they would like to have it next to them.</p> <p>During observation on 3/21/25 at 9:23 AM the Resident #16 was lying in bed on their back. The call bell was on the floor behind the folded floor mattress and out of the resident's reach. The resident stated that they could not find the call bell today again. The resident stated that when they needed assistance and could not find the call bell they screamed to call the staff.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 3/21/25 at 9:31 AM Certified Nurse Aide #3 stated that when they started their shift, they checked all assigned residents and a call bell for every resident during their shift. Certified Nurse Aide #3 entered Resident #16's room to observe the call bell and stated they could not find it. They asked the resident about their call bell. Resident #16 stated that they could not see it. Certified Nurse Aide #3 reached over the folded floor mattress, which was next to the wall and found the call bell. They stated that the call bell must have been moved by staff when serving the breakfast. They stated they had not checked the resident's call bell since the beginning of the shift.</p> <p>10 NYCRR 415.5(e)(1)</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>50766</p> <p>Based on record reviews and interviews during a recertification survey from 3/18/25-3/21/25 the facility did not ensure a resident's right to be free from misappropriation of resident property for 1 out of 1 resident (Resident #12) reviewed for personal property. Specifically, Resident #12 was missing shirts which was reported to facility staff and the facility did not complete a timely and thorough investigation of the missing property.</p> <p>Findings include:</p> <p>The facility policy titled Missing Items, dated March 2012, documented the facility shall respond to all reports of resident missing property. Once a resident or their representative reports an item missing to any facility staff member immediate action will be taken. Procedure: Clinical staff member asks for details regarding the missing item and completes Missing Item Report form. The form is given to the unit Social Worker. The Social Worker reviews missing item report, interviews the resident and family as appropriate, summarizes steps taken to locate item and documents results of the search. Social Worker notifies resident/designated representative if item has been located or not and documents the conversation on the form.</p> <p>Resident #12 had diagnoses including Polyneuropathy, peripheral vascular disease, and anxiety disorder.</p> <p>The annual Minimum Data Set (a Resident assessment tool) dated 1/3/25 documented Resident #12 was cognitively intact.</p> <p>During an interview on 03/19/25 at 9:21 AM, Resident #12 stated that some clothing had not come back from laundry or was missing (golf shirts with short sleeves). Resident #12 stated their spouse reported the missing items to facility staff about two weeks ago. They stated they were not aware of any follow-up regarding missing items.</p> <p>During an interview on 03/20/25 at 1:39 PM, Resident #12's spouse stated that approximately 1.5-2 weeks ago, they noticed that approximately 8 golf style short sleeved shirts were missing from Resident #12's closet. They stated they reported the missing items to the Unit Manager Registered Nurse the same day. They followed up with the Unit Manager Registered Nurse a couple of days later and were told that they reported missing items to Director of Housekeeping who was investigating. Resident #12's spouse stated they had not received any further follow-up on missing items and had not been reimbursed. They stated all the missing items were labeled when bought into facility.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 03/20/25 at 1:53 PM and on 3/21/25 at 10:32 AM, Unit Manager Registered Nurse #1 stated that Resident #12's spouse reported missing golf shirts to them, and they reported the missing items to the Direct of Housekeeping the same day and Housekeeping was investigating. They could not recall if they spoke directly to Director of Housekeeping or left a message. They stated they did not fill out a Resident Missing Property report for the missing items. They stated they were not aware of a report that needed to be completed. Unit Manager Registered Nurse #1 stated resident missing items were verbally discussed during morning staff meetings and that the facility Social Worker was present at the meetings. They stated they could not recall if they discussed missing shirts during morning meetings after receiving report from the resident's spouse. During an observation of files during interview, the Unit Manager Nurse Manager found blank Missing Items forms. They stated that the form should have been completed and given to Social Worker, the Director of Nursing or the Director of Housekeeping.</p> <p>During an interview on 03/20/25 at 3:23 PM, the Director of Housekeeping stated they did not receive a phone call, email, or Missing Item report from Unit Manager Registered Nurse regarding missing items for Resident #12 and had not investigated.</p> <p>During an interview on 03/20/25 at 3:40 PM, the Director of Social Work stated that a Missing Item Report form was used in the facility to report missing items. They stated any staff member could complete the forms, which were located at nurse station, and that the Unit Manager Registered Nurse usually completed and distributed the form. They stated were unaware Resident #12 had missing items.</p> <p>During an interview on 03/20/25 at 3:57 PM, the Director of Nursing stated residents/ advocates usually reported missing items to the nursing staff on the unit. The Certified Nurse Aide would search the resident's room for missing items. They will also confirm that the items came into facility on the Resident inventory listing. If Nursing was unable to locate missing items, they would contact the Director of Housekeeping to start investigation. If the missing items were not found by the Director of Housekeeping, the entire unit would be searched by nursing staff and the housekeeping department. If items were not found, a grievance form would be initiated by the Unit Manager and provided to the Social Worker. The Social Worker would discuss the missing items with the interdisciplinary team and contact the resident/advocate. The Administrator would make the final decision on reimbursement if necessary. They stated they were not aware Resident #12 was missing items.</p> <p>10 NYCRR 415.4(b)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50766</p> <p>Based on record review and interview during a recertification survey from 3/18/25 to 3/21/25, the facility did not ensure resident received treatment and care consistent with professional standards of practice for 1 of 2 Residents (Resident #13) reviewed for skin conditions. Specifically, Licensed Practical Nurse #1 failed to report a change in Resident #13's skin condition.</p> <p>Findings included:</p> <p>The facility policy titled Body Audits, reviewed 6/2017, documented body audits (skin checks) will be done on admission, re-admission and weekly thereafter per treatment order. The purpose is early identification for all potential and actual skin problems. Residents with additional factors such as bed mobility issues, paraplegia and cerebral vascular accident will be closely monitored.</p> <p>Resident #13 had diagnoses including cerebral infarction, flaccid hemiplegia right dominant side, and vascular dementia.</p> <p>The Quarterly Minimum Data Set (a Resident assessment tool) dated 1/24/25 documented Resident #13 had moderately impaired cognition and was dependent on staff for all activities of daily living, bed mobility and transfers.</p> <p>Physician order dated 5/1/23 documented a body audit every week with nurses notes one time weekly.</p> <p>The Skin Integrity care plan documented the resident was at risk for skin breakdown related to a history of previous skin breakdown. Interventions included monitoring for any skin breakdown and reporting to the physician/nurse practitioner.</p> <p>During an interview and observation on 03/18/25 at 01:21 PM, Resident #13's representative stated they observed an area of reddened skin behind the left ankle of Resident #13 earlier in the day and reported it to the Licensed Practical Nurse who also observed skin change. Resident #13's ankle was observed with the resident's representative and had a reddened area approximately 2-3-centimeter x .5 centimeters behind the left ankle area.</p> <p>During an interview on 03/20/25 at 9:08 AM, Certified Nurse Aide #5 stated Resident #13 was showered twice a week, and the nurse provided a skin check weekly. They stated Resident #13 was last showered Tuesday 3/18/25 and a skin check was completed by a nurse.</p> <p>During an interview and observation on 3/20/25 at 11:21 AM, Licensed Practical Nurse #1 stated a 2-3-centimeter blanchable reddened areas was observed behind Resident #13's left ankle. Licensed Practical Nurse#1 stated that Resident #13's representative did inform and show them the area of concern on the resident's left ankle. Licensed Practical Nurse #1 stated they applied bacitracin to the area and wrote their concern on a sheet of paper and planned to inform Unit Manager Registered Nurse #1 and forgot. They stated they had not applied bacitracin, followed up on skin change status or reported the change in skin condition to the Unit Manager Registered Nurse or physician since observing it on 3/18/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 03/20/25 at 11:26 AM, Unit Manager Registered Nurse #1 stated they were not informed by Licensed Practical Nurse #1 of a skin change for Resident #13. Unit Manager Registered Nurse #1 observed Resident #13's skin and stated there was a blanchable reddened area, approximately 3 centimeter x 0.5-centimeter area behind left ankle area. They stated Licensed Practical Nurse #1 should have reported the skin concern immediately to them. They stated that they would have contacted the physician, informed them of the change in skin status and obtained orders. They stated that Licensed Practical Nurse #1 should not have applied bacitracin without a physician order.</p> <p>During an interview on 03/21/25 at 2:39 PM, the Director of Nursing stated reported or observed changes in a resident's skin status should be escalated to nursing staff/ Unit Manager Registered Nurse immediately and an assessment of concern completed by Registered Nurse. The physician should be notified of the change and orders for care received and implemented. They stated that Bacitracin should not be applied without a physician order.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>50766</p> <p>Based on observation, interview, and record review conducted during the recertification survey from 3/18/25 to 3/21/25, the facility did not ensure residents were provided supervision to prevent accidents for 1 (Resident #33) of 2 residents reviewed for accidents. Specifically, Resident #33 was at risk for aspiration and was not provided supervision or assistance by facility staff during meals. The resident was observed being fed by an unqualified companion aide.</p> <p>The findings are:</p> <p>The facility policy titled Routine Resident Care, dated October 3, 2001, documented residents are given routine daily care by a Certified Nurse Assistant under the supervision of a Licensed Nurse. Routine care by a nursing assistant includes the following: assisting resident in personal care, bathing, dressing, eating and encouraging participation in physical, social, and recreational activities. Observing and recording all aspects of personal care including bathing, food intake, ambulation activities, elimination and vital signs on the Certified Nurse Assistant Accountability Sheet.</p> <p>The facility policy titled, Companion Policy, revised 10/24, documented the facility was to permit the use of Companions hired by a resident's family member or designated representative for specific needs of a resident for companionship or support. Companions are not permitted to give care to any resident within the Home's property. If a Companion does not comply or violates facility policies and procedures, the family or designated representative will be contacted and informed that the companion cannot return. The Companion responsibility included to socialize and converse with the resident, offer reality orientation, offer assurance, assist with hair grooming and applying makeup. Report any changes in resident's condition or any concerns regarding resident's condition to nurse. Push the resident's wheelchair or Geri chair.</p> <p>Resident #33 had diagnoses including metabolic encephalopathy, altered mental status and failure to thrive.</p> <p>The Quarterly Minimum Data Set (a Resident assessment tool) dated 1/17/25 documented Resident #33 was severely cognitively impaired, required partial/moderate assistance with eating and substantial / maximal assistance with bathing and dressing.</p> <p>A Physician's order dated 9/9/24 documented a mechanical soft diet and aspiration precautions as needed.</p> <p>The nutrition care plan, updated 9/30/24, documented the resident had poor intake and spits out food. The goals included the resident would tolerate the diet without signs and/or symptoms of aspiration. Interventions included a mechanical soft diet, to monitor for chewing and swallowing difficulty, and to provide assistance during meals.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and brief interview on 03/18/25 at 12:58 PM, private family hired companion aide was observed feeding Resident #33 lunch. The companion aide stated Resident #33 often refused to eat and shakes their mouth away. The companion aide stated they were not licensed and did not work for the facility.</p> <p>During an observation on 03/20/25 at 12:23 PM, Resident #33 was being fed a peanut butter and jelly sandwich and drinking fluids by the companion aide.</p> <p>During an interview on 03/20/25 at 09:03 AM, Certified Nurse Assistant #3 stated that Resident #33 had a private companion aide who assisted the resident from 11:00 AM until 4:00 PM. They stated that the companion aide did not provide cares to Resident #33, just sits with the resident, feeds the resident lunch and provides encouragement to eat.</p> <p>During an interview on 03/20/25 at 1:24 PM, Unit Manager Registered Nurse #1 stated Resident #33 required full assistance with eating. They stated facility Certified Nurse Aide staff provided feeding assistance for breakfast and dinner, and a private companion aide provided feeding assistance with lunch. They stated they thought the companion aide received training from the present or past Director of Nursing. They stated they did not supervise companion aides.</p> <p>During an interview on 03/21/25 at 8:35 AM, the Director of Nursing stated the facility had one privately hired companion aide in building at the current time. They stated that companion aides did not provide any cares, and only duties such as re-orientation and monitoring for safety. They stated they had not observed and were unaware the companion aide was feeding Resident #33.</p> <p>10 NYCRR 415.12(h)(2)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255</b></p> <p>Based on observation, record review and interviews during a recertification survey conducted from 3/18/25 to 3/21/25, the facility did not ensure the provision of nutrition and hydration care and services for 1 of 3 residents reviewed for Nutrition (Resident #5). Specifically, Resident #5 had a 6.3% weight loss over 1 month, and meal intake was not consistently monitored, and the resident was not encouraged with meal and fluid intake as planned.</p> <p>Findings include:</p> <p>The policy and procedure titled L.T.C. Evaluation of Changes Intake revised on January 2004 documented all staff members observe resident intake on a regular basis to evaluate change in resident food intake. Meal consumption is recorded by the Certified Nurse Aides daily for all residents in the Certified Nurse Aide Accountability Book. Nursing staff notifies the Food and Nutrition Services Department if a resident has consumed less than 75% of meals over a two-day period.</p> <p>The Resident #5 had diagnoses including diabetes mellitus, depression, and hemiplegia/hemiparesis following a cerebral infarction (stroke).</p> <p>The 2/11/25 Quarterly Nutritional Assessment documented Resident #5's appetite varied and average intake percent of meals was 25-75%. The resident triggered for an unplanned significant weight loss of 6.3% for 1 month. Recommendations included to add Glucerna twice a day for nutrition support, provide necessary assistance at mealtime and between meals, encourage oral meal and fluid intake, monitor oral intake of foods and fluids.</p> <p>The Minimum Data Set Quarterly assessment dated [DATE] documented the resident had severely impaired cognition and needed set-up assistance with eating.</p> <p>The 2/17/25 nutrition alteration care plan documented interventions included to monitor resident's daily intake, provide assistance during meals, encourage good meal and fluid intake, and offer specific food choices.</p> <p>During observation on 03/18/25 at 10:21 AM Resident #5 was in bed and stated that they did not eat breakfast, and they were hungry.</p> <p>During observation on 03/18/25 at 12:21 PM, the staff brought Resident #5 to the dining room for lunch and set up the meal tray in front of them. The resident ate a few bites of the main course and a small piece of desert with a cup of coffee. The staff did not provide assistance with the meal or encouraged the resident to eat.</p> <p>During observation on 03/21/25 at 12:35 PM the staff brought the Resident #5 to the dining room for lunch and set up the meal tray. The resident slowly started to eat, taking long pauses between bites. The resident ate about 50 % of the lunch. The staff did not provide assistance with the meal or encouraged the resident to eat.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The review of Activities of Daily Living Verification Worksheet revealed documentation of the resident's food intake: on 3/18/25 the breakfast intake 100% and lunch 100%; on 3/19/25 the breakfast intake 50% and lunch 25%; on 3/20/25 the breakfast intake 50% and lunch 0%; on 3/21/25 the breakfast intake 50% and lunch 50%.</p> <p>During an interview on 03/21/25 at 1:20 PM, Certified Nurse Aide #2 stated that sometimes they assisted the resident with their meal. Certified Nurse Aide #2 stated that they did not know how the resident's appetite was or if the resident had a recent weight loss. They said when a resident did not eat at all, they reported it to the nurse. Certified Nurse Aide #2 stated on 3/18/25 the resident did not eat breakfast, and they told the nurse. They said the resident ate less than 50% during lunch time on the same day, and they were not aware of care plan interventions to encourage the resident with meal and fluid intake. The Certified Nurse Aide #2 could not explain why they documented 100% food intake for breakfast and lunch on 3/18/25.</p> <p>During an interview on 03/21/25 at 01:29 PM, Licensed Practical Nurse #1 stated Resident #5 always ate well, and they were not aware of any recent weight loss. They stated when the resident did not eat well or at all, the Certified Nurse Aide would report it to the nurse and nurse would contact the physician. Licensed Practical Nurse #1 stated that they encouraged the residents to eat during mealtime if they saw a resident not eating well. Licensed Practical Nurse #1 stated that they were not aware the resident ate 50% of breakfast and 25% of lunch meal on 3/19/25.</p> <p>During an interview on 03/21/25 at 1:37 PM, Registered Nurse #1 stated the Certified Nurse Aides document the amount of food residents consumed during a mealtime in Certified Nurse Aide Accountability Record. Certified Nurse Aides did not have specific assignment to assist specific residents during meals.</p> <p>10NYCRR 415.12(i)(1)</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>45478</p> <p>Based on staff interview and review of facility documents, it was determined that, the facility did not ensure each certified nurse aide received twelve hours in-service education per year based on their individual performance review. Specifically, (1) 4 out of 5 certified nurse aides did not have their mandatory annual 12 hour in services and (2) 5 out of 5 certified nurse aides (#2,6, 7, 8, 9) did not receive performance evaluations.</p> <p>Finding Include:</p> <p>Review of facility training records revealed:</p> <p>Certified Nurse Aide # 2 was hired on 2/28/2011 and received 10.25 hours of in-services in the last 12 months and had no documented evidence of an annual performance review.</p> <p>Certified Nurse Aide # 6 was hired on 12/17/2007 and received 0 hours of in-services in the last 12 months and had no documented evidence of an annual performance review.</p> <p>Certified Nurse Aide # 7 was hired 8/23/1995, received 16 hours of in-services in the last 12 months, and had no documented evidence of an annual performance review.</p> <p>Certified Nurse Aide # 8 was hired 4/22/1998, received 10.5 hours of in-services in the last 12 months, and had no documented evidence of an annual performance review.</p> <p>Certified Nurse Aide # 9 was hired 7/20/2009, received 3 hours of in-services in the last 12 months, and had no documented evidence of an annual performance review.</p> <p>On 3/20/25 at 11:38 AM, the Certified Nurse Aide Mandatory 12 hours In-service and the Certified Nurse Aide performance evaluations were requested from the Director of Nursing. The Director of Nursing stated when they started working, they were just working on hiring Certified Nurse Aides and Licensed Practical Nurses and had not done any performance evaluations.</p> <p>On 3/20/25 at 12:07 PM, during an interview with the Director of Nursing, they stated they did not have any performance evaluations completed for the sampled selection of certified nurse aides.</p> <p>On 3/21/25 at 12:09 PM, during an interview with the Administrator, they stated they were not aware the certified nurse aide performance evaluations were not being done.</p> <p>03/21/25 at 2:21 PM, during an interview with the Director of Nursing, they stated when they were gathering the in-services and calculating the hours for the 5 certified nurse aides, they realized 4 out of 5 certified nurse aides did not meet the mandatory 12 hours of annual in-servicing.</p> <p>10NYCRR 415.26 (d) (7)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/21/2025
NAME OF PROVIDER OR SUPPLIER  Bethel Nursing Home Company Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  17 Narragansett Avenue Ossining, NY 10562	
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41666</p> <p>Based on observations, record review, and interviews during the recertification survey from 03/18/25 to 03/21/25, the facility did not ensure a medication error rate of no more than 5%, during a medication administration observation, when 3 of 35 opportunities (8.57%) resulted in error for 1 of 3 residents (Resident #19). Specifically, Resident #19 1) was administered a crushed form of Carbidopa50mg-Levodopa 200mg-entacapone, a crushed form of Acidophilus Probiotic 35 million cell tablet, and 2) an inaccurate dose of Metamucil powder.</p> <p>The findings are:</p> <p>Resident #19 was admitted to the facility with diagnoses including but not limited to Parkinson's disease, heart failure and hypertension. The Minimum Data Set (an assessment tool) dated 3/1/25 documented the resident had severe cognitive impairment, was dependent on staff for all activities of daily living and was prescribed a mechanical diet.</p> <p>1)The current physician orders as of 3/18/25 documented Carbidopa50mg-Levodopa-entacapone oral tablet, give one tablet by mouth two times a day for Parkinson's disease and Acidophilus 35million cell tablet 1 tablet by mouth one time daily. There were no orders to crush to crush any medications prior to administering medications.</p> <p>The current physician order as of 3/18/25 documented puree diet with thickened liquids-nectar thick.</p> <p>During a medication administration observation on 03/18/25 at 10:05 AM, Licensed Practical Nurse #1 was observed crushing Resident #19 Carbidopa50mg-Levodopa-entacapone oral tablet, and Acidophilus 35million cell tablet prior to mixing the medication with applesauce and was about to administer to Resident #19. The blister pack for the Carbidopa-Levodopa-entacapone and the Acidophilus contained a yellow, white and orange sticker which documented, swallow tablet whole. Do not chew, break or crush.</p> <p>During an interview on 03/18/25 at 11:59 AM, Licensed Practical Nurse #1 stated the resident always took their medicine crushed because it was the only way they could get the resident to take their medications, as they could not swallow pills. They stated the saw the label noted do not crushed but crushed anyway and did not inquire if another form was available.</p> <p>During an interview on 03/19/25 at 3:56 PM, Registered Nurse Unit Manager #1 stated the resident did not have an order for crushed medications. They stated if a resident had their extended-release medications crushed the resident would get a larger dose of the medication all at once.</p> <p>During an interview on 03/19/25 at 10:41 AM, Physician #1 stated nurses should always follow and give medications according to the manufacturer guidelines. If the direction said do not crush, then a question should have been asked.</p> <p>2) Resident #19's current physician orders as of 3/18/25 documented Metamucil 3.4gm/5.4gm oral powder, administer 1 tablespoon daily.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bethel Nursing Home Company Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  17 Narragansett Avenue Ossining, NY 10562	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the medication administration observation on 3/18/25 at 10:05 AM Licensed Practical Nurse #1 used an eating utensil spoon to remove the Metamucil from the container and put it in a cup. A tool that measured a tablespoon was not used by the nurse to measure before putting it in the cup.</p> <p>During an interview with Licensed Practical Nurse #1 on 3/18/25 at 10:35 AM they were asked how they ensure the resident was getting the correct dose of Metamucil if they were not using a measuring spoon. They stated they looked in the canister, and it appeared there was none, so they used a regular spoon.</p> <p>During an interview with the Registered Nurse Unit Manager #1 on 03/19/25 at 10:52 AM they stated nurses always needed to measure accurately to make sure the resident was getting the right dose. They stated a new canister of Metamucil should have been ordered and measuring with a regular teaspoon was not accurate.</p> <p>10NYCRR 415.12(m)(1)</p>

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NAME OF PROVIDER OR SUPPLIER  Bethel Nursing Home Company Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  17 Narragansett Avenue Ossining, NY 10562	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>45478</p> <p>Based on observation, record review, and interview during the recertification survey the facility did not maintain drugs and biologicals, labeled in accordance with currently accepted professional standards, and include the appropriate accessory and cautionary standards, and expiration dates for 1 of 1 medication storage room (located on the second floor) reviewed. Specifically, the medication storage room (located on second floor) had expired drugs and biologicals that were available and ready for use.</p> <p>The findings include:</p> <p>The facility policy on Storage of Medications last revised 12/2023 documented discontinued, contaminated or deteriorated medications are removed from the medication/treatment storage area and disposed of per facility policy.</p> <p>On 03/19/25 at 10:03 AM, the Second-Floor Short term and Long term Medication Storage Room was observed with expired medicine and products including the following:</p> <ul style="list-style-type: none"> <li>-2 boxes omeprazole, one box had 3 bottles in it with a total 42 pills and the second box had 2 bottles in it with a total of 28 pills and both boxes expired 2/2024.</li> <li>-3 boxes Assure Platinum (50 ct) strips expired 5/4/2024.</li> <li>-2 boxes Assure Prism Control Solution Blood Glucose Monitoring Expired 10/2023.</li> <li>-1 box curos needless connectors (270 caps) expired 8/2024.</li> <li>-1 box bisacodyl (box of 100) suppositories expired 6/2024.</li> <li>-BD Insyte Autoguard needle lot6253728 exp 8/31/2019.</li> <li>-BD Insyte Autoguard winged needle lot1133998 expired 4/30/2024.</li> <li>-BD Insyte Autoguard needle lot 6169783 exp 5/31/2019.</li> <li>-BD Insyte Autoguard needle lot 9305162 exp 10/31/2022.</li> <li>-BD Insyte Autoguard needle lot 1090022 exp 3/31/2024.</li> <li>-Foley 2 way stabilization lot JUCXF054 expired 9/28/2021.</li> <li>-Kangaroo e pump ENplus Spike Set Lot 200480120 expired 1/31/2023.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/25 at 10:05 AM during an interview, Registered Nurse Unit Manager #1 stated they must have only checked the carts and not the med storage room.</p> <p>On 3/19/25 at 12:34 PM during an interview, Licensed Practical Nurse #1 stated they gave out medication to the residents and also checked the medication storage room for expired medications and other products. Licensed Practical Nurse #1 stated they checked for expired medications on the top shelf and did not check the 2 storage bins with drawers where the expired items were located.</p> <p>On 3/21/25 at 10:00 AM during an interview, Registered Nurse Unit Manager #1 stated the med storage room was audited on Mondays on the night shift. Registered Nurse Unit Manager #1 stated Licensed Practical Nurse #1 may check their cart and the room as a standard, but it was the night shift's role to check the medication room and carts for expired medications and products.</p> <p>10 NYCRR 415.18(e)(1-4)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51902</p> <p>Based on observations and interviews conducted during the recertification survey from [DATE] to [DATE], the facility did not store, distribute and serve food in accordance with professional standards for food service safety and did not maintain dishwasher heat for sanitation. Specifically, 1) expired foods were stored in dry pantry, walk in refrigerator and freezer; 2) unsealed, unlabeled and undated food were stored in dry pantry and walk in refrigerator; 3) the dishwasher wash and rinse did not maintain proper temperature standards; and 4) three (3) staff were observed not performing proper hand hygiene while serving the lunch meal.</p> <p>Findings include:</p> <p>The facility policy last revised ,d+[DATE], Labeling and Dating stated any unopened food item will be discarded by the manufacturer labeled expiration date and all prepared menu items will be dated in compliance of a 3 day use by date.</p> <p>The facility policy last reviewed ,d+[DATE], Food Storage stated contents of opened food packages will be stored in tightly sealed containers and all containers will be properly labeled as to contents.</p> <p>The facility policy reviewed ,d+[DATE], Dish Machine Temperature Log included documentation of acceptable wash temperature should not fall below 150 degrees F and rinse temperatures not below 180 degrees F.</p> <p>The facility policy reviewed,d+[DATE], Proper Hand Sanitation stated employees must also thoroughly wash their hands after touching their body and after coming in contact with residents. Employees must always change gloves before beginning a different task and as soon as they become soiled.</p> <p>1) During the initial tour of the kitchen on [DATE] at 9:24 AM with Dietary Staff #1 and Food Service Director it was observed in the pantry five bags of marshmallows with expiration date of [DATE], in the refrigerator an opened jar of clam base with expiration of ,d+[DATE], a case of individual frozen chicken pot pies in the freezer with expiration date of ,d+[DATE], and in the basement pany a jar of Maraschino cherries with expiration date of ,d+[DATE]. The Food Service Director stated they did not use the maraschino cherries; they had been left by previous Food Service Director. Dietary Staff #1 disposed of all expired items.</p> <p>2) On the same tour an unlabeled, undated plastic container of chunks of chicken was found inside a box on the top shelf of the pantry. Dietary Staff #1 stated it was chicken from last evenings dinner and a diet aide probably placed it there to eat later and left it by mistake. Opened bags of cornbread stuffing (spilling out of bag and onto crate), biscuit mix, and dried pasta were observed in the pantry not sealed and not labeled. Individual cups of applesauce, pudding and salads were stored in the refrigerator with no date. The Food Service Director stated the items were to be used at lunch or by the end of day and stated they knew they needed to label the items.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) During an observation on [DATE] at 10:18 AM, wash temperature on the dish machine was 148 degrees F and the rinse temperature was 150 degrees F. When interviewed at the time of observation, the Food Service Director stated the dishwasher was working fine earlier. Temperature logs were reviewed with the Food Service Director, and documented temperatures within the normal range. They stated if dish machine continued to not work properly, they would call the service company to repair if needed.</p> <p>During an observation on [DATE] at 10:14 AM the dish machine wash temperature was not at temperature (148 degrees) and the rinse temperature was (154 degrees), not at temperature guidelines. When interviewed at the time of observation, the Regional Food Service Director stated they would switch to chemical sanitizer until it could be fixed.</p> <p>During an interview on [DATE] at 12:35 PM, the Regional Food Service Manager stated the heat booster in dish machine had been condemned by the service company and dish machine was switched to chemical sanitizer.</p> <p>4) During a lunch meal observation in the dining room on [DATE] at 12:39 PM, the Food Service Director served multiple residents' plates of food while wearing disposable gloves. While wearing the disposable gloves they touched Resident #11 shoulder, scratched their own neck, held food cart handle to move cart, and loaded Resident #9 meal to cart to take to their room. At 12:51 PM Food Service Director removed disposable gloves to make a phone call and continued to serve residents' plates of food and did not use hand sanitizer.</p> <p>During an interview on [DATE] at 2:45 PM the Food Service Director stated she thought she was supposed to wear the disposable gloves when passing plates of food at meals.</p> <p>During an observation on [DATE] at 12:25 PM, Certified Nurse Aide #1 touched Resident #33's legs multiple times to adjust them in their recliner chair. Certified Nurse Aide #1 then went into kitchenette to pour cups of hot beverages, touched the handles of cups, and loaded a cart with meal trays to take to the residents eating in their rooms. They did not use hand sanitizer between touching Resident #33 legs and completing the other tasks. During an interview on [DATE] at 12:27 PM Certified Nurse Aide #1 stated she was in a hurry to assemble the trays and forgot to use hand sanitizer.</p> <p>During an observation on [DATE] at 12:28 PM, Certified Nurse Aide #2 used their thumb and fore finger to pull up their face mask to cover their nose and then held Resident #5's hand and placed a fork in the resident's hand. Certified Nurse Aide #2 continued to deliver lunch meals to three other residents and then assist Resident #15 with feeding. Certified Nurse Aide #2 did not use hand sanitizer during these tasks.</p> <p>On [DATE] at 1:43 PM the Director of Nursing was interviewed and stated staff was to sanitize their hands whenever they switch tasks.</p> <p>10 NYCRR 415.14(h)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41666</p> <p>Based on observation, record review and interview conducted during a recertification survey from 3/18/25 to 3/21/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for all residents. Specifically, the facility did not provide documentation of screening, administration, or declination and education provided for 5 of 10 staff (Certified Nurse Aide #1 and #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3) reviewed for influenza and 10 of 10 staff (Certified Nurse Aide #1, #2, #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3, Director of Environmental Services, Director of Housekeeping, Physical Therapist #1 and Housekeeping Aide #1) reviewed for pneumococcal vaccination.</p> <p>The findings are:</p> <p>The facility policy titled Prevention, Early Detection and Control of Influenza dated 6/2023 documents the purpose is to control the spread of respiratory infections which includes a preventative vaccination program. All staff members will be offered the influenza vaccine on an annual basis. A master line listing of all residents and staff is to be maintained for all influenza vaccinations administered.</p> <p>The facility did not provide a Pneumococcal Vaccination Policy.</p> <p>During the recertification survey the facility was asked to provide documentation that influenza vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for Certified Nurse Aide #1 and #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3 but none was provided. In addition, the facility was asked to provide documentation that pneumococcal vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for (Certified Nurse Aide #1, #2, #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3, Director of Environmental Services, Director of Housekeeping, Physical Therapist #1 and Housekeeping Aide #1 but none was provided.</p> <p>During an interview on 03/20/25 at 01:36 PM with the Infection Preventionist</p> <p>they stated they are the Preventionist for a few facilities and forwards consents and declinations to Human Resources when they obtain them from staff. The Infection Preventionist stated they have not been keeping a list of which staff has consented and received the influenza vaccination and who has declined. In addition, they stated they have not been offering or keeping track of pneumococcal vaccination for staff. If staff had the vaccine, then fine but not offering it or educating staff.</p> <p>During an interview with the Director of Nursing on 03/20/25 at 01:18 PM they stated vaccine information is sent to the Human Resources offsite for the new hires. They do not get pneumococcal status and has not been keeping track of vaccines since they started at the facility two months ago but stated it was important and was aware it should be done.</p> <p>10NYCRR 415.19 (a)(1-3)</p> <p>(continued on next page)</p>		

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F 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	51902

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>41666</p> <p>Based on observation, record review and interview conducted during a Recertification survey from 3/18/25 to 3/21/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for all residents. Specifically, the facility did not provide documentation of screening, administration or declination and education provided for 10 of 10 staff (Certified Nurse Aide #1, #2, #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3, Director of Environmental Services, Director of Housekeeping, Physical Therapist #1 and Housekeeping Aide #1), reviewed for COVID vaccination.</p> <p>The findings are:</p> <p>The facility COVID policy dated 12/24/20 documents newly hired staff will be asked to provide COVID vaccination information as part of their Human Resources medical record as they do with other vaccines. If they are unvaccinated, or not up to date, they will be provided education on COVID19 and offered the COVID vaccine.</p> <p>During the recertification survey the facility was asked to provide documentation that COVID vaccination was offered, education was provided, and staff had the opportunity to consent or decline the vaccine for Certified Nurse Aide #1, #2, #4, Licensed Practical Nurse #1, Registered Nurse Supervisor #1, Dietary Aide #3, Director of Environmental Services, Director of Housekeeping, Physical Therapist #1 and Housekeeping Aide #1 but none was provided.</p> <p>During an interview with the Infection Preventionist on 03/20/25 at 01:36 PM they stated the facility had not been offering the COVID vaccination to staff and did not give a reason as to why it had not been done.</p> <p>During an interview with the Director of Nursing on 03/20/25 at 01:53 PM they stated they had been at the facility for a few months and COVID vaccinations had not been offered to staff to her knowledge. The Director of Nursing stated they did not know why it was not being offered to staff but it was important and should have been done.</p> <p>10NYCRR 415.19 (a)(1-3)</p>		