Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335497	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trustees of Eastern Star Hall & Home of the N Y S	8290 State Rt 69 Oriskany, NY 13424

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48446 Based on observations and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure the results of the most recent Federal/State survey were posted in a place readily accessible to residents, family members, and legal representatives of residents for 1 of 1 Federal Health Recertification survey. Specifically, the results of the most recent Federal health recertification survey conducted 2/23/20223 were located behind the reception desk on a high shelf and was not accessible to all without having to ask for assistance. Findings include: During a Resident Council meeting on 11/6/2024 at 1:56 PM, eight anonymous residents in attendance stated they did not know they could view the previous survey results and did not know where the results were located. During an observation on 11/7/2024 at 3:45 PM, the State Survey binder was on a shelf on a table behind the reception desk in the main entrance to the building. The area was not accessible to residents or visitors. During an interview on 11/7/2024 at 4:46 PM, Receptionist #4 stated if a resident or family wanted to see the State Survey binder for the previous survey, they would have to ask them for it. They stated residents or visitors did not go behind the reception desk and the survey results were too high for residents to reach especially from a wheelchair. During an interview on 11/8/24 at 8:19 AM, Social Worker #3 stated it was a resident right to view the previous survey results. The results were located at the reception area and in Administration. They were not sure if residents could access them without asking. The results used to be posted in a living room, but they were moved when the living room was no longer being used. During an interview on 11/8/2024 at 9:38 AM, the Administrator stated it was a resident right to have survey results available and accessible without asking for them. They were not aware the results were not accessible without asking staff for assistance as they were new to the role as the facility Administrator. 10NYCRR 415.3(c)(v)

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48052 Based on record review and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 1 of 3 residents (Resident #276) reviewed. Specifically, Resident #276 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident with timely Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) when Medicare Part A coverage was ending and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A as required. Findings include: The Center for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055, expiration date 1/31/26, documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending. Resident #276 had diagnoses including cerebral vascular accident (stroke), aphasia (difficulty speaking), and anxiety. The 8/5/2024 Minimum Data Set assessment documented it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment and the resident had a Medicare-covered stay with a start date of 5/7/2024 and an end date of 5/23/2024. The resident had moderately impaired cognitive skills for daily decision making. The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #276's effective end date of services was 5/23/2024. The handwritten note on the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage documented the Notice of Non-coverage Center for Medicare and Medicaid Services-10055 was not provided because the resident resumed Medicaid coverage. The facility policy regarding Beneficiary Notification was requested on 11/7/2028 and on 11/8/2024 at 3:16 PM, Administrative Assistant # 7 stated the facility did not have a policy regarding notice of Medicare non-coverage. During an interview on 11/8/2024 at 11:23 AM, Accounts Receivable Coordinator #19 stated they determined who received an Advanced Beneficiary Notification if the resident remained in the facility and had no other payor resource. They did not give the form to residents with Medicaid because Medicaid would pick up coverage for the residents stay. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/2024 at 12:59 PM, the Administrator stated they were familiar with the Notice of Medicare Non-coverage and Advanced Beneficiary Notices, however, was not involved in the process. They stated residents who remained in the facility that came off Medicare Part A needed an Advanced Beneficiary Notification. They were not aware accounts receivable was not issuing them to residents who had Medicaid and should have been. 10 NYCRR 483.10 (g) (18)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 48052 Based on record review and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure they assessed residents using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services (CMS) not less frequently than once every 3 months for 3 of 70 residents (Residents #14, #16, and #50) reviewed. Specifically, Residents #14's, #16's, and #50's Minimum Data Set assessments were completed later than 14 days after the Assessment Reference Date (the final day of the observation period to gather information about a resident's condition when completing the assessment). Findings include: 1) Resident #14 had diagnoses including lymphedema (disrupted flow of lymph fluid), heart failure, and hypertension. The quarterly Minimum Data Set assessment documented an Assessment Reference Date of 9/18/2024 and was completed on 10/28/2024. 2) Resident #16 had diagnoses including lung cancer, peripheral vascular disease, and arthritis. The quarterly Minimum Data Set assessment documented an Assessment Reference Date of 12/26/2023 and was completed on 2/2/2024. 3) Resident #50 had diagnoses including Alzheimer's disease, renal failure, and depression. The quarterly Minimum Data Set assessment documented an Assessment Reference Date of 9/7/2024 and was completed on 10/24/2024. During an interview on 11/8/2024 at 8:19 AM, Social Worker #3 stated the Minimum Data Set Assessments were done by Minimum Data Set Coordinator #18. They were done upon admission, annually, quarterly, and with any significant change. They were used to get a picture of the residents' needs and to develop the plan of care. They were also required to receive reimbursement from Medicare and Medicaid. They were unaware of resident assessments not being current. During an interview on 11/8/2024 at 3:16 PM Administrative Assistant #17 stated the facility did not have a policy regarding Minimum Data Set Completion. (continued on next page)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 11/8/2024 at 8:26 AM, Minimum Data Set Coordinator #18 stated they were the only person completing Minimum Data Set Assessments on a 92 day rotation which allowed for wiggle room if they needed it. They stated the facility recently had an influx of admissions and they were behind. When they started in this position the process was completed by the interdisciplinary team and when staff from the interdisciplinary team decreased, they were asked to complete more sections until they were completing the entire assessment. Resident #14 should have had their assessment done by 10/14/2024 and submitted by 10/16/2024. It was not completed until 10/28/2024. Resident #16's assessment should have been completed by 1/9/2024 and submitted by 1/23/2024 and was not completed until 2/2/2024. Resident #50's assessment should have been completed 9/21/2024 and submitted by 10/6/2024 and was submitted 10/24/2024. They stated the assessments were late because they were behind. During an interview on 11/8/2024 at 11:15 AM, the Administrator stated Minimum Data Set Assessments were the responsibility of Minimum Data Set Coordinator #18. They were completed upon admission, quarterly, and with any significant change. If they were not done timely the resident could have a decline and the care plan would not be current. 10NYCRR 415.11(a)(4)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48052 Based on record review, and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice for 1 of 1 resident (Resident #218) reviewed. Specifically, Resident #218 did not have their ordered blood sugars documented in the medical record and were not available for the medical provider's review. Findings include: The undated facility policy, Protocols for Diabetic Residents, documented if a resident on insulin had a blood sugar over 240 (milligrams/deciliter) the provider was notified the following day. If the resident had a blood sugar of 420 and was symptomatic the provider was informed. If the residents blood sugar was 420 and the resident was not symptomatic the provider was informed the following day. Residents with blood sugars less than 60 were given glucagon (a hormone that raises blood sugar levels) 1 milligram injection in the muscle under nursing supervision with a blood sugar repeated every 30 minutes until the blood sugar was over 90. Resident #218 had diagnoses including diabetes. The Minimum Data Set assessment had not been completed as the resident was a new admission. Physician orders documented: - on 11/4/2024 Lantus Solostar (long-acting insulin) U-100 Insulin 100 unit/milliliter (3 milliliter) subcutaneous (under the skin) pen; inject 25 units by subcutaneous route once daily. - on 11/5/2024 morning blood sugar at AM before breakfast and at bedtime at 7:00 AM and 8:00 PM. The 11/5/2024 provider admission progress note documented Resident #218 was admitted with Type 2 Diabetes Mellitus with unspecified complications. They were on a diabetic diet. Medications were ordered for Tradjenta 5 milligrams daily, Jardiance 10 milligrams daily, and [NAME] insulin 25 units twice daily. The resident's blood sugars were to be monitored and medication would be adjusted as needed. The 11/2024 Treatment Administration Record documented monitor blood sugars before breakfast and at bedtime at 7:00 AM and 8:00 PM. - on 11/5/2024 the 7:00 AM blood sugar was marked with a dash and no nurse initials. The 8:00 PM blood sugar was marked as completed by Licensed Practical Nurse #21. Neither time had a documented blood sugar result. - on 11/6/2024 the 7:00 AM blood sugar was marked as completed with no documented blood sugar result. The 8:00 PM blood sugar was documented as completed by Licensed Practical Nurse #21 with no documented blood sugar result. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no documented blood sugar results in the 11/5/2024 or 11/6/2024 nursing progress notes. During an interview on 11/8/2024 at 10:32 AM, Licensed Practical Nurse #21 stated they cared for Resident #218 the last few nights and the resident had an order for blood sugars to be completed every evening at 8:00 PM. They stated they did not think there was a place in the electronic record to document the blood sugar results. They stated they obtained the resident's blood sugar, thought they had recorded it, but could not remember where. They stated If a blood sugar was not documented in the electronic medical record, it was not completed. On 11/8/2024 at 11:32 AM a telephone interview was attempted with Physician #15. A voicemail message was left with no return call prior to survey exit. During an interview on 11/8/2024 at 11:55 AM, the Director of Nursing stated testing blood sugars required an order from the provider. All blood sugars should be recorded in the electronic chart or on a paper Medication Administration Records. If blood sugars were not documented, it was a medication error and if a blood sugar was too low and the resident received insulin it could cause a diabetic reaction. 10NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48052 Based on observations, record review, and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 1 resident (Resident #37) reviewed. Specifically, Resident #37 did not have their pressure ulcer wound vacuum dressing (a vacuum assisted wound closure device that uses suction to help heal wounds) changed every three days as ordered. Findings include: The undated facility policy, Pressure Ulcer Prevention Treatment Plan, documented a skin care plan would be initiated on admission and carried forth through discharge to assure prevention, early detection, and treatment of any pressure ulcer. Interdisciplinary wound care observations were made on residents with Stage 2 to Stage 4 pressure areas per the treatment plan of care at least weekly by the Nurse Manager and the nutritional services personnel. The facility policy, Care Planning, dated 11/2017, documented an individualized comprehensive care plan that included measurable objectives and timetables to meet the residents medical, nursing, mental and psychological needs was developed for each resident upon admission. Resident #37 had diagnoses including pressure ulcer to the sacral region (low back, buttocks area), sepsis (system wide infection), and Parkinson's Disease (a progressive neurological disorder). The 8/3/2024 Minimum Data Set assessment documented the resident was cognitively intact, required substantial assistance for most activities of daily living, had an unstageable (full thickness tissue loss in which the base of the ulcer cannot be visualized) pressure ulcer that was not present on admission, and received application of nonsurgical dressings. The Comprehensive Care Plan revised 8/16/2024 documented the resident had skin breakdown from pressure to their sacral area. Interventions included turning and positioning every 2 hours, wound care rounds weekly, and pressure relieving devices as appropriate. The care plan did not include the use of a wound vacuum. A 10/10/2024 outside Wound Care Physician progress note documented the resident had a sacral pressure wound which had improved. The wound was debrided (removal of dead tissue) and was a Stage 3 (full thickness tissue loss). The plan was to begin wound vacuum assisted closure at 125 millimeters of mercury (pressure reading) with black foam, 3 times per week. The dressing to be used until the vacuum was started and daily back up dressing if the vacuum needed to be removed for any reason was skin prep to the peri ulcer, collagenase (an enzyme used to remove dead tissue), Mesalt (a dressing used to manage heavily draining wounds), ABD pad (a thick bandage), and secure with tape. Physician #15 medical order renewals documented: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 10/25/2024 if wound vacuum loses suction for more than 2 hours clean wound with normal saline, pat dry, cut Mesalt sodium chloride to size, place on wound bed, and cover with super absorbent foam dressing as needed. - 10/28/2024 skin prep (skin protectant) to peri wound (area surrounding the wound). Wound VAC (vacuum assisted closure, a device that uses suction to help heal wounds). Apply predrape (keeps a seal and eliminates leaks), fill wound with black foam, apply track pad (tubing used for suctioning) to appropriate side. Wound vac set to 125 millimeters of mercury (pressure). Change every three days on the day shift. The 11/2024 Treatment Administration Record documented: - skin prep to peri wound, apply predrape, fill wound with black foam, apply track pad to appropriate side. Wound vacuum set at 125 millimeters of mercury, change dressing 3 times weekly with a start date of 10/29/2024 at 12:30 PM. Administer during 7:00 AM-3:00 PM shift and as needed. The treatment scheduled for 11/4/2024 was not documented as administered and had a - in the corresponding box. Licensed Practical Nurse #16 signed for Resident #37's other treatments administered on 11/4/2024 during the 7:00 AM-3:00 PM shift. There were no documented nursing notes addressing the resident's wound vacuum dressing change for 11/4/2024. During an observation and interview on 11/7/2024 at 9:43 AM, Registered Nurse Supervisor #10 stated the wound vacuum dressing was ordered to be changed every three days. The dressing was observed and dated 11/1/2024. They removed the old dressing dated 11/1/2024 and stated the dressing was ordered to be changed 11/4/2024 and was not changed. They stated because the dressing was not changed as ordered the foam was really stuck to the wound bed. In an effort not to remove new tissue, they had to soak off the old dressing. They used two bottles of normal saline and waited several minutes to remove the old dressing. The wound had a foul odor. They stated when dressings were not changed as ordered the resident's wound could worsen and become infected. During an interview on 11/8/2024 at 10:43 AM, Licensed Practical Nurse #16 stated the wound vacuum dressing for Resident #37 was changed every three days. They stated when the treatment was scheduled on their day, they notified the Nurse Manager as they were not trained on how to care for a wound vacuum and were not going to change the dressing. They stated the Unit Manager was going to educate them on how to care for the wound vacuum dressing but had been too busy and had not completed the education yet. They stated they did not document the dressing was changed on 11/4/2024 because they did not change it and was not trained on it. If the dressing was not changed as ordered the resident can get an infection in the wound. During an interview on 11/8/2024 at 11:55 AM, the Director of Nursing stated 10 nurses, including Unit Managers and licensed practical nurses received training on wound vacuums from the company that manufactured the wound vacuums. They did not believe Licensed Practical Nurse #16 attended the training. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	If staff was not trained on the wound vac, they should notify the Registered Nurse Supervisor and document in the electronic record who was notified. If the dressing was not done as ordered the resident could get an infection, become septic, and the wound could worsen. If the dressing was dated 11/1/2024 when changed 11/7/2024 the dressing was not done as ordered. 10NYCRR 415.12(c)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48052 Based on observations, record review, and interviews during the recertification and abbreviated (NY00353222) surveys conducted 11/5/2024-11/8/2024 the facility did not ensure the resident environment remained as free of accident hazards as is possible for 1 of 3 residents (Resident #26) reviewed. Specifically, the facility did not ensure egress doors were secure and Resident #26 was able to exit through the doors and was found in the stairwell, scooting down the steps on their bottom. Findings include: Resident #26 had diagnoses including dementia, difficulty walking, and history of falling. The 6/7/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, did not exhibit wandering behaviors, did not walk, required substantial/maximal assistance for transfers, used a manual wheelchair, was dependent for wheelchair mobility, and did not use a wander/elopement alarm. The comprehensive care plan initiated 10/24/2022 documented Resident #26 had cognitive impairment. Interventions included increasing cognitive levels for activities of daily living, safety, and quality of life. The resident had an alteration in functional status with interventions including extensive assistance of one for transferring. The resident was at risk to fall, and interventions included appropriate footwear, request assistance with transferring, engage in activities, keep the environment free from clutter, bed in the lowest position, call bell in reach, and respond to the call light promptly. The updated 9/6/2024 care plan documented the resident was at risk for elopement and interventions included redirecting negative behaviors, regularly assessing for elopement risk, social services evaluation, and monitoring ankle alert. The 8/31/2024 Nursing Elopement Risk Assessment documented Resident #26 was not at risk for elopement. The 9/3/2024 at 5:15 AM incident report completed by Licensed Practical Nurse #24 documented Resident #26 was not in their room and they began searching for the resident in the hallway and rooms. The resident was found in the stairwell by a dietary aide. The resident was scooting down the stairwell steps on their buttocks when found. Contributing factors included increased confusion, the resident was awake earlier than usual that morning. The investigation summary documented the resident was able to self-propel in their wheelchair. A reenactment was completed using video footage. The resident was observed pushing open the door and was able to get through the door with a lot of difficulty but was able to do so. A wander alert device was applied. The incident was reviewed by the Director of Nursing on 9/7/2024. There was no documented evidence how the resident was able to exit through a door without being noticed or without the door alarming. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/3/0243 at 5:22 PM Social Worker #3 progress note documented Resident #26 was found sitting on the bottom of the stairs in the stairwell. The resident was evaluated by nursing staff with no noted injury. The resident was alert however cognitively impaired related to diagnosis of dementia. As a rule, does not engage in conversations and it takes a lot of encouragement to get them to respond with one or two words. In light of this, a wander guard has been placed on her person as well as her wheelchair. During an observation and interview on 11/8/2024 at 8:49 AM, Licensed Practical Nurse #14 stated the door to the stairwell to the right when looking at the receptionist desk alarmed and was able to be turned off. They stated this was the stairwell Resident #26 was found in on 9/3/2024. When attempting to open the door, the bar moved however did not unlock. Licensed Practical Nurse #14 stated to release the door, you had to hold the bar for 45 seconds. After 45 seconds the door still did not release. Licensed Practical Nurse #14 stated you can put in a code and the door would alarm until the code was entered a second time. During an interview on 11/8/2024 at 9:11 AM, Maintenance Director #7 stated they checked the doors annually and visually on a weekly basis. After putting in a code there was 15 seconds to get through the door before it alarmed. The door would not open without a code. They were aware Resident #26 got into the stairwell on 9/3/2024. They did not believe they were questioned about the doorways during the investigation. After the incident they checked all the doors, and they were functioning. They were not sure how the resident got through the doors if they were locked and functioning. They did not believe the door was ever unlocked as it was an entrance for staff and the door had always alarmed after being opened for more than 15 seconds. During an interview on 11/8/2024 at 1:20 PM, Licensed Practical Nurse #24 stated on 9/3/2024 while a certified nurse aide was changing Resident #26, they went to another unit to administer medications. When they returned Resident #26 was missing so they called a code for a missing resident. They located the resident in the stairwell on the middle of the stairs. The door to the stairwell was not locked and did not alarm after 15 seconds. They were unsure how long the door was unlocked prior to the incident or why it was unlocked. During an interview on 11/8/2024 at 11:55 AM, the Director of Nursing stated they arrived at the facility after getting a call about Resident #26 getting into the stairwell on 9/3/2024. The resident was located at approximately 5:30 AM when dietary staff came through the staff entrance and saw the resident 1-2 steps from the bottom stair scooting down the stairs on their buttocks. After the incident part of the plan of correction was putting a keypad on the door. There was not a keypad on the door at the time and the door was not locked as it was an employee entrance. The door was not a fire door with a delayed egress for as long as they had been employed. During an interview on 11/8/2024 at 12:59 PM, the Administrator stated at the time of the 9/3/2024 incident with Resident #26 the door was an employee entrance and exit. The fire doors in the hallways were usually closed at night to deter wanderers from going across the center. After the incident the door was secured. 10 NYCRR 415.12(h)(1)(2)

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NAME OF PROVIDER OR SUPPLIER: Trustees of Eastern Star Hall & Home of the N Y S		STREET ADDRESS, CITY, STATE, ZIP CODE: 8290 State Rt 69 Oriskany, NY 13424	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33421 Based on observations, record review, and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure drugs and biologicals were stored in accordance with currently accepted professional standards for 2 of 2 medication carts ([NAME] and [NAME] Unit's medication carts); 1 of 2 medication rooms ([NAME] Unit); and 1 of 2 treatment carts ([NAME] unit). Specifically, the [NAME] and [NAME] Units medication carts had expired stock medications and insulin; the [NAME] medication room had expired stock medications and biologicals; and the [NAME] treatment cart was unlocked and unattended. Findings include: The undated facility policy, Storage and Maintenance of Medication, documented all drugs and biologicals were stored in the locked designated cabinets and stored under proper temperature controls. All medications, except those requiring refrigeration, were kept in locked medication carts and cabinets. Medications must be checked regularly for expiration dates and deterioration. Expired medications were removed from use and returned to the pharmacy. Bottles of eye drops, insulin, inhalers etc., were dated when opened and a sticker placed for 30 days to discard. A list of treatment cart contents received from the facility included: -medicated creams and ointments -urinary catheter bag covers -wound cleanser -adhesive bandages -hearing aids -hearing aid batteries -personal shavers -medicated shampoos -dressing supplies (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/6/2024 at 11:53 AM, the treatment cart on [NAME] unit was unlocked. The treatment cart contained individual trays with resident names. The items in the trays included diclofenac sodium cream (nonsteroidal anti-inflammatory) and clotrimazole betamethasone dipropionate (a topical antifungal). Licensed Practical Nurse #13 stated they did not lock the treatment cart after removing hearing aid batteries earlier that day. They stated the cart should be locked because it contained medicated creams. During an interview on 11/6/2024 at 11:58 AM, Registered Nurse Supervisor #10 stated the treatment cart should be locked. On 11/6/2024 at 1:09 PM, the [NAME] Unit medication room was observed with Licensed Practical Nurse #11. A shelf contained an opened bottle of Vitamin B-12 1000 micrograms with a manufacturer's expiration date of 9/2024. The medication refrigerator contained 2 boxes (17 syringes total) of single dose Afluria (influenza vaccine) 0.5 milliliter syringes with manufacturer's expiration date of 5/31/2024. Licensed Practical Nurse #11 stated those medications were expired and should have been disposed of. They stated all nurses were responsible for checking the medication carts and rooms for expired medications prior to giving any medication. They were unsure if someone was assigned to perform medication room and cart checks on a scheduled basis. On 11/6/2024 at 1:15 PM the [NAME] Unit medication cart was observed with Licensed Practical Nurse #12. The middle drawer of the cart contained an opened bottle of antacid tablets with a manufacturer's expiration date of 7/2024. On the side of the bottle was a handwritten opened date of 9/8/2024. Licensed Practical Nurse #12 stated they were unaware of any resident who received the antacid. Any nurse opening a bottle and/or administering a medication should check the expiration date prior to opening the bottle or giving the medication. On 11/6/2024 at 1:25 PM the [NAME] Unit medication cart was observed with Licensed Practical Nurse #13. The top drawer of the cart contained an opened bottle of multivitamins with iron with a manufacturer's expiration date of 4/2024; an opened bottle of aspirin 81 milligrams with no legible manufacturer's expiration or opened date; an opened bottle of aspirin 325 milligrams with a manufacturer's expiration date of 7/2024; and a Glargine (insulin) pen with no opened date on the pen and no plastic bag for the pen. Licensed Practical Nurse #13 stated they gave the resident insulin from the pen that morning and gave another resident an 81 milligram aspirin from that bottle this morning. They expiration dates were checked every night shift. All nurses should check the expiration dates prior to administration of medications. They did not check the expiration dates prior to administration as they trusted the night shift nurse removed all expired medications. During an interview on 11/8/2024 at 9:13 AM, Licensed Practical Nurse Manager #14 stated stock medications were kept in the medication rooms on each unit. All medications should be checked for expiration dates when unit staff were ordering par levels for the unit. All medications should be checked in the medication rooms, the medication carts, and the medication refrigerators when checking monthly stock inventory. Any expired medication was to be disposed of. Each nurse should check the expiration date prior to administering a medication. If an expiration date was not readable, it was deemed expired. Insulin was only good for 30 days past the open date, therefore, if there was no opened date, it was considered expired. It could be harmful for a resident to receive an expired medication depending on the medication's purpose. The treatment cart contained supplies and prescribed treatments like creams which could harm a resident if they were ingested. The treatment cart should have been locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/8/2024 at 12:20 PM, the Director of Nursing stated all day shift nurses should check the medication carts and rooms for expired medications. All medications should be labeled with an opened date. No opened date on insulin meant the medication was expired as the insulin was only good for 30 days once opened. Any stock medication without a legible expiration date was considered expired. Any expired medication bottle past the expiration date should not be opened and the medication not given to a resident. All treatment carts should be locked if unattended as they contained medicated creams which could be harmful if a resident got into them. 10NYCRR 415.18(d) 48446

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522 Based on observations, record review, and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, the main kitchen had unclean, scratched, and dented ceiling tiles, unclean ovens, pans with baked on debris, and expired cannisters of 3 bay sink sanitizer test strips. Findings include: The facility policy, Cleaning Procedure Conventional Ovens, updated ,d+[DATE], documented conventional ovens interiors and exteriors were cleaned daily. The interior was cleaned with detergent solution with special attention to the corners. The exterior was cleaned with stainless steel cleaning solution. The following observations were made in the main kitchen: - on [DATE] at 6:31 PM the dish machine area ceiling tiles were not cleanable, and were scratched, dented, and damaged. - on [DATE] at 6:35 PM two ovens were unclean on the inside and outside. - on [DATE] at 9:00 AM four pans on a clean pot rack had baked on debris and were not clean. - on [DATE] at 9:20 AM two cannisters of sanitizer test strips for the 3 bay sink had an expiration date of [DATE]. -on [DATE] between 9:00 AM and 9:20 AM, the ceiling tiles were not cleanable, and were scratched, dented, and damaged. During an interview on [DATE] at 9:17 AM, Interim Food Service Director #5 stated they were aware the ceiling tiles in the kitchen that were unclean, scratched, damaged, and dented and were not cleanable. They stated the outside of the two ovens were unclean and not acceptable. They were not able to locate a specific cleaning schedule for outside of the ovens. They stated the 4 pans on the pot rack were old and should have been taken out of service. They verified the two canisters of sanitizer strips located near the three bay sink were expired [DATE] and they were responsible for checking the sanitizer strip dates. It was important the main kitchen was kept clean manner, so residents and staff did not get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:00 AM, Kitchen Supervisor #6 stated there were damaged, dented, and chipped ceiling tiles, that were not cleanable. Once the tiles were dented or chipped those regular tiles could not be cleaned and needed to be replaced. It was the cook's responsibility to clean inside and outside the two ovens. They stated the ovens were cleaned twice a week by the night cooks. They verified 4 pans had baked on debris and should have been discarded. They were not aware the sanitizer test strips were expired. The Food Service Director was responsible for ensuring strips were not expired. The previous Food Service Director left 2 weeks ago. They stated it was important to keep a clean kitchen to avoid pests and for the safety of residents. 10NYCRR 415.14(h)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522 Based on observations and interviews during the recertification survey conducted 11/5/2024-11/8/2024, the facility did not ensure there was an effective pest control program for the main kitchen and the [NAME] Unit. Specifically, fruit flies and drain flies were observed in the main kitchen and on the [NAME] Unit. Findings include: The facility pest control policy was requested on 11/7/2024 and was not received. The following observations were made: - on 11/5/2024 at 6:18 PM approximately 5 drain flies and 5 fruit flies were in the main kitchen dish machine room. - on 11/6/2024, between 9:00 AM and 9:20 AM 2 drain flies and 5 fruit flies were in the main kitchen dish machine room. - on 11/6/2024 at 10:08 AM there were ten fruit flies in the [NAME] Unit Kitchenette. - on 11/6/2024 at 10:10 AM there was one fruit fly on the ceiling near the housekeeping closet on the [NAME] Unit. - on 11/8/2024 at 8:45 AM 2 live drain flies and 10 live fruit flies were in the main kitchen dish machine room. During an interview on 11/8/2024 at 9:17 AM, Interim Food Service Director #5 stated pest control service came every three weeks and was last at the facility two weeks ago. They were not aware of fruit flies or drain flies in the kitchen as staff did not report them. They had only been covering the facility for two weeks and stated it was important to maintain a pest control program for the safety of residents, so they do not get sick. During an interview on 11/8/2024 at 10:00 AM, Kitchen Supervisor #6 stated a pest control service came monthly. They were aware of the fruit flies and drain flies and stated fruit flies could come in by bringing in outside food. They had not seen a lot of fruit flies since being hired and because there was no odor in the dish machine area, they were not sure where the drain flies were coming from. They had not reviewed or maintained the monthly pest control log and was not given any directions to eliminate pests. It was important to review and maintain the pest control logs for food safety and the safety of the residents. They were not aware of fruit flies in the [NAME] unit kitchenette or hallway. During an interview on 11/8/2024 at 11:25 AM, Director of Environmental Services #7 stated they could not find any monthly pest control logs from 3/2023 through 10/2024. On 10/17/2024, immediately after the previous Food Service Director left the facility, they had secured a new vendor agreement to complete pest control. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/2024 at 11:15 AM the Administrator stated they expected the facility to be free from pests. The Food Service Director oversaw the kitchen. They stated they had only been the Administrator since August and when they realized there was not a pest control program, they reached out to different vendors and signed with a pest control vendor in October 2024. They stated if there were pests in the facility, it was not homelike for residents. 10 NYCRR: 415.29(j)(5)