STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335504	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seneca Health Care Center	2987 Seneca Street West Seneca, NY 14224

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36415 Based on interview and record review conducted during the Standard survey completed on 11/8/24, the facility did not ensure the resident has the right to exercise his or her rights as a resident of the facility and as citizen or resident of the United States for one (Resident #119) of one resident reviewed for voting. Specifically, Resident #119 was not afforded the right to vote in the November 2024 Presidential Election. The finding is: The policy and procedure titled Residents' Rights: Voting dated 10/2024 documented the facility affirm and support the right of residents to vote. The Activities Department, with the assistance of nursing, will evaluate the resident's voting ability and preferences upon admission and as needed. The resident's voting preferences will be documented on the care plan. Current regulations under Residents' Rights related to exercising the right as a citizen of the United States to vote, including the use of mail for mail-in or absentee ballots include exercise of rights: the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The facility will ensure residents can exercise their right to vote, whether in-person by mail, absentee ballot, or other authorized process. The facility will coordinate and engage with voting programs, as appropriate. This may include mobile polling in residential facilities performed by a bipartisan team of workers and/or assistance in registering to vote, requesting an absentee ballot, or completing a ballot from an agent of the resident's choosing, including a family representative, LTC (long term care) Ombudsmen or nursing home staff (or other personnel permitted to perform these functions, per state law). For residents who are otherwise unable to cast their ballots in-person, the facility will ensure residents have the right to receive and send their ballots via the U.S. Postal Service, or other authorized mechanism allowed by the State or locality. Resident #119 had diagnoses including depression, diabetes, and anxiety. The Minimum Data Set (a resident assessment tool) dated 8/27/24 documented Resident #119 was cognitively intact, was understood, and understands. The Minimum Data Set documented it was very important for Resident #119 to do their favorite activities. The comprehensive care plan revised on 11/20/23 documented Resident #119 was independent with decision-making skills. Interventions included provide information to make safe/independent decisions, respect choices and voting: registered to vote. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Activities Review with effective date 3/19/24 and 8/6/24 documented Resident #119 had an intervention that documented registered to vote. The Resident Council Meeting Minutes dated 9/26/24 documented new business: residents wanting to vote for U.S President in upcoming election. The meeting minutes were signed by the Resident Council President and Director of Activities. Resident #119 was recorded as attending the Resident Council Meeting. Review of an absentee ballot request documented the absentee ballot request was received by the County Board of Elections for Resident #119 on 10/7/24 and it would be mailed to the facility address. The documented contained ways to contact the County Board of Elections including two phone numbers, an address, and an email. Review of the nursing progress notes 9/1/24 through 11/7/24 lacked documented evidence that Resident #119 was provided with the opportunity to vote in the November 2024 Presidential Election. During an interview on 11/5/24 at 8:22 AM, Resident #119 stated they were told approximately three weeks prior that they would be able to vote. They stated voting was very important, so much that it was crucial. They stated the Activities Director was supposed to communicate to a voting department and voting people would come in but nobody ever came. During an interview on 11/7/24 at 12:07 PM, Resident #119 stated they gave up and never received an election ballot. During an interview on 11/7/24 at 12:21 PM, the Activities Director stated they oversaw assisting the residents to vote. They stated they started at the end of September to early October, they approached every resident in the facility to find out who wanted to vote in the election. They stated they were told by the County Board of Elections that if they had 32 or more residents interested in voting then they would send people to the facility to assist in voting. The Activities Director stated they had 32-35 residents who had wanted to vote so they called the number of a staff member at the County Board of Elections and left a voicemail. The Activities Director stated through the month of October, they called that same staff member at the County Board of Elections, left a message, and never received a call back. They stated they then called the main phone number at the County Board of Elections and spoke to the Principal Election Clerk on 10/31/24. They stated they were able to get some of the absentee ballots for the residents but not all of them and they could not remember if Resident #119's ballot was completed or not, but they should have been able to vote because it was their right. They stated they did not document anywhere in the electronic medical record if Resident #119 voted or not. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/8/24 at 10:10 AM, the Principal Election Clerk stated they were considered a point person at the County Board of Elections for Skilled Nursing Facilities. They stated a representative at the facility would fill out absentee applications to vote and if there were 25 or more residents who wanted to vote then they would send a bipartisan team to assist the residents. They stated the facilities do not need to wait until election time to register the residents to vote, especially if they were staying long term, they could register at any point in the year. They stated the facility had completed the registrations as temporary, and they would expire in December. They stated if they completed the registration marking that they resident had a permanent illness/disability, then they would receive a ballot ever year without having to re-register the long-term care residents. They stated they had 17 voters at the facility receiving absentee ballots and Resident #119 had an online application for a ballot request, but a ballot was not received back by the County Board of Elections. The Principal Election Clerk stated the facility had until 10/26/24 to register and request an absentee ballot for the residents who wanted to vote in the Presidential Election and until Election Day to either have the ballots post marked or dropped off at a pulling site. During an interview on 11/7/24 at 3:23 PM, the Activities Director stated the Resident Roster dated 10/21/24 was the only documentation they had that indicated what ballots were mailed in. If the Resident's name was highlighted that meant that Resident's ballot was mailed in. They stated they did mail in a good chunk of ballots and kept the Administration at the facility updated on the process, but they did not ask for any help with requesting absentee ballots, completing the ballots, or mailing them in. A Resident Roster dated 10/21/24 provided by the Activities Director, documented have ballot's need to mail in. Mailed in. 12 Resident names were highlighted on the document. Resident #119 was not highlighted. During an interview on 11/8/24 at 12:00 PM, the Administrator stated they felt the staff at the County Election Board were the ones that dropped the ball. They stated the Activities Director oversaw the entire process, went resident to resident asking if they wanted to vote, and had a list of maybe 30 people who were interested. They had to re-register the residents which may have been the beginning of the problem and then they waited for the team from the Election Board to come in and they never came in. They stated they felt that the Activities Director followed up with the Election Board accordingly and did their diligence. 10NYCRR 415.3(d)(1)(i)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, record review, and interview conducted during the Standard survey completed on 11/8/24, the facility did not ensure residents had the right to choose activities, schedules, and health care consistent with their interests, assessments, and plan of care for two (Resident #3 and #119) of three residents reviewed for choices. Specifically, Resident #3 was provided bed baths instead of showers as planned and per their preference; Resident #119 was not provided with showers twice a week per their preference. The findings are: The policy and procedure titled Resident Preferences and Accommodation of Needs revised on 11/4/21, documented the resident has a right to reside and receive services in the facility with reasonable accommodations of individual needs, personal, and cultural, expect when the health or safety of the individual or other residents would be endangered. Residents will be offered the opportunity to participate in formulation of their plan of care, morning and bedtime routines and bath schedules. The policy and procedure titled Bathing and Grooming revised 2/2019 documented tub baths or showers are given by all nursing personnel as scheduled/preferred. The policy and procedure titled Resident Rights and Responsibilities revised on 4/2/24 documented it is the objective of the facility to provide the Patient/Resident with optimal nursing and psychosocial care. Every effort is made by the staff to meet the Patient/Resident's individual needs and requirements. 1. Resident #3 had diagnoses including diabetes mellitus, chronic obstructive pulmonary disease (lung disease) and obesity. The Minimum Data Set, dated dated dated [DATE], documented Resident #3 was understood and understands and was cognitively intact. The Minimum Data Set documented, Resident #3 was dependent for transfers, required substantial/maximal assistance (helper does more than half of the effort) for showering and there were no refusals of care. The Annual Minimum Data Set, dated dated dated [DATE] documented it was somewhat important for Resident #3 to choose between a tub bath, shower, bed bath, or sponge bath. The comprehensive care plan reviewed 10/9/24 documented Resident #3 had a self-care performance deficit for bathing related to activity intolerance and limited mobility. Interventions included supervision for upper body bathing and maximal assistance with one assist for lower body bathing, showers on Thursday on 3:00 PM-11:00 PM shift. The care plan documented Resident #3 was independent with decision making skills and interventions included to offer choices related to care routine. Review of the Visual/Bedside Kardex (a guide used by staff to provide care) dated 11/8/24, documented Resident #3 was to have a shower on Thursdays on the 3:00 PM-11:00 PM shift. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The north unit shower book located at the nurse's station contained Quality Improvement Skin Inspection sheets dated 7/31/24, 8/22/24, 9/19/24, and 10/24/24 that documented Resident #3 had received bed baths. There were no showers documented as given from 7/31/24 -10/24/24. There were no sheets dated after 10/24/24. Review of the Progress Notes dated 10/1/24 through 11/8/24 revealed no documented evidence Resident #3 had received or refused their showers. During an interview on 11/4/24 at 10:46 AM, Resident #3 stated it had been about a year since they had been able to use the shower, they stated they received bed baths but preferred a shower. Resident #3 stated they had been told by several staff that the shower beds would not hold over 300 pounds and that they were over the weight limit to use a shower bed. Resident #3 stated they had been told by therapy it was not safe for them to use the shower bed because of their weight. Resident #3 stated it was important for them to take a shower instead of a bed bath to prevent infections. During an interview on 11/6/24 at 12:27 PM, Licensed Practical Nurse #5 stated they were unsure how staff determined whether residents required the use of a shower chair or shower bed, it might be on the care plan. Licensed Practical Nurse #5 stated that bed baths would be given in place of showers only if that was the resident's preference or if they were ill. During an observation and interview on 11/7/24 at 9:22 AM, Certified Nurse Aide #5 stated Resident #3 received a bed bath because the shower beds would not hold over 300 hundred pounds. They stated Resident #3 had been aware of the weight capacity issue and they were unsure the last time Resident #3 was able to take a shower. Certified Nurse Aide #5 stated they were not sure where the weight capacity was listed for shower beds but believed it was on the back of the shower bed. Observed the shower beds and a shower chair located in the shower room with Certified Nurse Aide #5 present. There was no weight capacity listed on them. During an interview on 11/7/24 at 11:02 AM, the Assistant Director of Nursing/Infection Preventionist (covering as Unit Manager for the north unit) stated that Resident #3 was scheduled to have showers and was not aware of any reason Resident #3 could not use the shower bed. They stated that therapy determined whether a resident used a shower bed or shower chair for bathing and was unaware of what the weight capacity was for the shower equipment, they would check with the maintenance director. During a follow up interview on 11/7/24 at 1:42PM, the Assistant Director of Nursing/Infection Preventionist stated they had verified the weight capacity of the shower beds with the maintenance director and reviewed the manufacturer's manual for the shower beds. They stated that all facility shower beds had a weight capacity of 450 pounds and there were no residents in the facility that exceeded this weight capacity. The Assistant Director of Nursing/Infection Preventionist stated Resident #3 should have received their showers and was unsure who would have informed Resident #3 that they were over the weight capacity for the shower beds. They stated it was important to honor Resident #3's preferences because it was their home. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 2:53 PM, the Director of Rehabilitation stated that physical therapy and occupational therapy completed quarterly evaluations on all residents to determine shower assistance and transfers. They stated that they were not aware of any therapy staff stating Resident #3 would not be safe to use a shower bed for bathing. The Director of Rehabilitation reviewed Resident #3's physical and occupational therapy discharge summary notes dated 10/1/24 from the electronic medical record and stated Resident #3 transferred with a mechanical lift and would have been safe to use the shower bed. During an interview on 11/8/24 at 12:00 PM, Licensed practical nurse #5 stated they believed Resident #3 received bed baths instead of showers because of a weight limit issue. They stated they were unsure who had said there was a weight limit on the shower beds, but it was the general impression the staff on the unit had. Licensed Practical Nurse #5 stated they were not aware of the specific weight capacity for shower beds and chairs. During an interview on 11/8/24 at 11:37 AM, the Director of Nursing stated that showers and baths were determined based on resident's preferences and would expect staff to honor resident preferences because it was what they requested. The Director of Nursing stated they were unaware Resident #3 was not receiving their showers and was unsure who had informed Resident #3 that they were over the weight capacity for the shower bed. The Director of Nursing stated based off the actual weight capacity of the shower beds, they would have expected staff to have provided Resident #3 with their shower because it was their preference. 2. Resident #119 had diagnoses including depression, diabetes, and morbid obesity. The Minimum Data Set, dated dated dated [DATE] documented Resident #119 was understood, understands, and was cognitively intact. Resident #119 required partial/moderate assistance with bathing. Review of the comprehensive care plan revised on 8/27/24 documented Resident #119 had a self-care performance deficit related to activity intolerance, impaired balance and limited mobility. An intervention revised on 4/9/24 documented Resident #119 was scheduled to have a shower on Wednesdays during the 7:00 AM-3:00 PM shift. Review of the Nursing Admission Evaluation dated 11/18/23 documented Resident #119 preferred to have two showers per week. The Visual Bedside/Kardex dated 11/7/24 documented Resident #119's shower was scheduled on Wednesdays on the 7:00 AM-3:00 PM shift. Review of the north unit shower book located at the nurse's station, revealed Resident #119 was scheduled for one shower on Wednesdays during the 7-3 shift. Review of the Quality Improvement Skin Inspection sheets, located in the shower book, dated 9/4/24 through 11/6/24, revealed Resident #119 received one shower a week. Review of the nursing progress notes 8/1/24-11/7/24 revealed no documented evidence that Resident #119 was offered or given more than one shower per week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 8:22 AM, Resident #119 stated they wanted to two showers per week, and they asked a Certified Nurse Aide in the past, but they told them they could not have more than one shower a week because there were too many residents. Resident #119 stated after they were told no, they did not ask anyone else because they thought everyone would give the same answer. During an interview on 11/7/24 at 12:13 PM, Certified Nurse Aide #6 stated they looked at the shower list in the shower binder at the nurse's station to know which residents were scheduled for a shower and it was the unit coordinator who updated the shower schedule. Certified Nurse Aide #6 stated residents were showered once a week, but some were showered twice a week. They stated after a resident was showered, whoever gave the shower would fill out a skin inspection sheet and the nurse would then sign off that the shower was given. Certified Nurse Aide #6 stated if a resident wanted to have two showers the shower list should be updated because it was the residents' choice, and it would make them happy. During an interview on 11/8/24 at 8:11 AM, Licensed Practical Nurse #7 stated usually residents received a shower once a week unless they were on the subacute unit or had a preference. They stated upon admission, residents were asked how often they would like showers. Licensed Practice Nurse #7 stated usually it was the unit coordinator who was responsible to make the shower schedule. They stated when residents voiced their preference for when they wanted a shower, it should be followed because it's their choice and for their dignity. During an interview on 11/8/24 at 8:19 AM, the Assistant Director of Nursing/Infection Preventionist (covering as Unit Manager on the north unit) stated if Resident #119 wanted an additional shower during the week they should have notified a nurse or the Assistant Director of Nursing. They stated if the Certified Nurse Aide was asked by Resident #119 for an additional shower every week, then it was the responsibility of the Certified Nurse Aide to communicate that to a nurse. The Assistant Director of Nursing stated they were unaware that Resident #119 wanted two showers a week and unfortunately, they did not check the original admission evaluation or care plan when Resident #119 moved units. During an interview on 11/8/24 at 8:57 AM, Licensed Practical Nurse #8, who completed the Nursing Admission Evaluation, stated when they completed admission evaluations, they would ask the resident how many showers they wanted per week and then update the shower schedule. They stated it was important for residents to choose how often they wanted a shower because it was their personal preference and choice. They stated the unit coordinators or nurses on the unit would be responsible for communicating shower preference when residents moved units. During an interview on 11/8/24 at 9:47 AM, Social Worker #1 stated unless a family member or resident came to them asking for a change with their care, they were not responsible for updating residents' preferences. They stated when a resident changed rooms from one unit to another, they were responsible to let the responsible party know the resident was moving units. They stated they were unaware Resident #119 wanted two showers a week. Social Worker #1 stated during admission and room changes, it was the responsibility of the nursing staff to ask Resident #119 their preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/8/24 at 11:45 AM, The Director of Nursing stated it was expected for residents' preferences to be followed and updated as they requested. They stated Resident #119 should have been offered showers twice a week because they requested showers twice a week and that was their preference. They stated it should have been communicated they wanted two showers a week when they changed units and the Certified Nurse Aide that they told should have communicated their preferences to the nurse. The Director of Nursing stated it was the responsibility of the Social Workers to ask residents their preferences every quarter. 10 NYCRR 415.5 (b)(3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00351900) during the Standard survey completed on 11/8/24, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for three (Resident #1, #16 and #96) of eight residents reviewed. Specifically, Resident #1 was observed with greasy hair, Resident #16 and Resident #96 were observed to have dried brown debris under their fingernails. The findings are: The policy and procedure titled Bathing and Grooming revised 2/2019, documented residents were bathed as often as necessary to maintain cleanliness. Tub baths or showers are given by all nursing personnel as scheduled/preferred. The policy and procedure titled Nail Care revised on 10/11 documented the purpose was to ensure cleanliness and to prevent infection. Routine nail care was to be done following a bath/shower whenever possible. 1. Resident #1 had diagnoses that included multiple sclerosis (a progressive disease, involving nerve cells in the brain and spinal cord, that can cause numbness, impairment of muscular coordination), acquired absence of kidney, and type 2 diabetes mellitus. The Minimum Data Set (a resident assessment tool) dated 7/1/24 documented Resident #1 was cognitively intact, was understood, and understands. The Minimum Data Set documented it was very important for Resident #1 to choose between a shower and a bed bath, and the resident was dependent on staff for showers. The comprehensive care plan revised on 9/12/24, documented Resident #1 had a self-care deficit for bathing related to multiple sclerosis, activity intolerance and limited mobility. The resident required maximal assist of two staff for upper body and were dependent on two staff for their lower body. The Visual/Bedside Kardex (a guide for staff providing care) dated 11/8/24 documented Resident #1 was to have shower on Mondays on the 7:00 AM-3:00 PM shift and they required maximal assist of two staff for upper body and were dependent on two staff for their lower body. During an interview and observation on 11/5/24 at 8:29 AM, Resident #1 was lying in bed with their hair pulled back. Resident #1's hair was visibly greasy. Resident #1 stated they had not received their shower yesterday (11/4/24) and a bed bath was not offered. During an interview on 11/7/24 at 9:56 AM, Certified Nurse Aide #3 stated they were unable to give Resident #1 a shower on Monday (11/4/24) due to some staffing conflicts. Certified Nurse Aide #3 stated they updated the Unit Manager, who went and spoke with Resident #1 regarding the issue. Certified Nurse Aide #3 stated Resident #1 was understanding and accepted the offer to receive a shower the next day (11/5/24). Certified Nurse Aide #3 stated Resident #1 was given a bed bath on Tuesday (11/5/24). Certified Nurse Aide #3 stated they had not documented or updated the nurse that Resident #1 received a bed bath instead of a shower, and they should have. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 12:36 PM, Licensed Practical Nurse #4 Unit Manager stated they were aware Certified Nurse Aide #3 was unable to give Resident #1 a shower on their scheduled shower day, Monday, and spoke with the resident themself. Licensed Practical Nurse #4 stated Resident #1 received a bed bath the next day, Tuesday. Licensed Practical Nurse #4 stated residents should be offered showers, especially if it was important to them. During an interview on 11/7/24 at 12:42 PM, Resident #1 stated they would really like their hair washed and were unable to have it washed if they didn't receive a shower. Resident #1 stated Certified Nurse Aide #3 came in and gave them a bed bath and did not offer a shower on Tuesday. Resident #1 stated they usually only end up receiving one actual shower a month, so their hair was only washed once a month, and that bothered them. During a follow up interview on 11/7/24 at 12:56 PM, Certified Nurse Aide #3 stated they had noticed that Resident #1's hair was greasy during the bedbath and they did not wash the resident's hair. They stated Resident #1 had not mentioned wanting their hair washed. Certified Nurse Aide #3 stated it was important for residents to have their hair washed for dignity reasons. During an interview on 11/8/24 at 12:41 PM, the Director of Nursing, in the presence of the Administrator, stated they expected staff to ask residents if they wanted a shower. The Director of Nursing stated they would have expected Certified Nurse Aide #3 to offer Resident #1 their shower. They stated shower days were listed in the resident's care plan and Certified Nurse Aides and nurses were responsible for ensuring showers were given according to the care plan. The Director of Nursing stated they would have expected Certified Nurse Aide to update the nurse if a bed bath was given instead of a shower. They stated it was a resident right to receive showers according to their care plan. The Administrator stated they agreed with what the Director of Nursing stated. 2. Resident #16 had diagnoses which included anxiety, and depression, and adult failure to thrive. Review of the Minimum Data Set (a resident assessment tool), dated 10/7/24, documented Resident #16 was cognitively intact, understood and understands and required partial/moderate assistance for personal hygiene. The Visual/Bedside Kardex Report (a guide for staff to provide care), dated 11/7/24, documented that Resident #16 required minimal assistance for personal hygiene and nail care on bath day (Friday 3:00 PM-11:00 PM shift) and as needed. The comprehensive care plan, revised on 9/27/24, documented the resident had a self-care performance deficit related to limited mobility, and limited range of motion. The plan included to provide verbal cues/encouragement. Resident #16 required maximum assistance for bathing. During observations on 11/4/24 at 9:00 AM and 11/5/24 at 9:01 AM, Resident #16 had long fingernails with brown debris underneath all nails. During an interview on 11/5/24 at 9:05 AM, Resident #16 stated the aides don't cut their fingernails. Their shower day was on Fridays, and they haven't had a shower in a couple of weeks, staff haven't offered to clean or cut their nails. Resident #16 stated they hoped they could get a manicure with activity staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further observations on 11/5/24 at 3:34 PM, 11/6/24 at 9:10 AM, and 11/7/24 at 9:11 AM, Resident #16 had long fingernails with dried brown debris underneath. During an interview on 11/7/24 at 11:17 AM, Certified Nurse Aide #3 stated nails were trimmed and cleaned on bath/shower days but were checked daily with care. Nails could be trimmed and cleaned anytime. During an observation and interview on 11/7/24 at 11:20 AM, Licensed Practical Nurse #4 Unit Manager observed Resident #16's fingernails and stated the nails were long, dirty and possibly cleaned during the bed bath on 11/1/24 but not trimmed. There's no way they'd grow that fast in six days. During a telephone interview on 11/7/24 at 12:26 PM, Certified Nurse Aide #4 stated they did not trim Resident #16's fingernails on 11/1/24. Typically, they would document that nail care was provided on the shower sheets but did not have time. During a telephone interview on 11/8/24 at 10:51 AM, Licensed Practical Nurse #3, Nurse Educator stated nail care was important for the resident's comfort, hygiene, and cleanliness. Dirty nailbeds could cause infection. During an interview on 11/8/24 at 11:57 AM, the Assistant Director of Nursing/Infection Preventionist stated nurses and certified nurse aides were responsible to ensure activities of daily living were completed, especially nail care and showers. Nail care was basic hygiene and should be provided daily. During an interview on 11/8/24 at 12:41 PM, the Director of Nursing, in the presence of the Administrator, stated Certified Nurse Aide #4 should have cleaned and trimmed Resident #16's fingernails after the bed bath on 11/1/24. Resident #16 had the right to receive proper care including nail care. Nails should be cleaned daily and cleaned and trimmed on shower days whether they had a shower or a bed bath. 3. Resident #96 had diagnoses which included dementia, depression, and anxiety. The Minimum Data Set, dated dated dated [DATE], documented Resident #96 was sometimes understood, sometimes understands, was severely cognitively impaired and had no refusals of care. Resident #96 required partial/moderate assistance for personal hygiene. The Visual/Bedside Kardex Report dated 11/7/24, documented Resident #96 required moderate assistance for personal hygiene and nail care was to be provided on bath day and/or as needed. The comprehensive care plan, revised on 1/9/22, documented Resident #96 had a self-care performance deficit related to activity intolerance, Alzheimer's Disease (dementia), impaired balance and limited mobility. Interventions included moderate assistance and nail care on bath day and/or as needed. Review of the nursing progress notes dated 10/1/24 through 11/5/24, revealed no documented evidence Resident #96 refused nail care. During an observation on 11/4/24 at 10:36 AM, Resident #96 was eating a Danish with their right hand. Their fingernails on both hands were trimmed but had dried brown debris under them. Resident #96's fingers of their right hand were observed to enter their mouth as they ate their Danish. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/5/24 at 11:45 AM, Resident #96's fingernails on both hands had dried brown debris underneath them. During an observation on 11/6/24 at 8:11 AM, Certified Nurse Aide #7 provided morning care for Resident #96. While assisting Resident #96 with washing their hands, Certified Nurse Aide #7 stated to Resident #96 that they needed to have their fingernails cleaned but would do that later. During an observation on 11/6/24 at 8:49 AM, Certified Nurse Aide #7 provided Resident #96 with their breakfast tray and handed the resident a banana. Resident #96's fingernails were observed with brown debris under them while they were eating the banana. During an interview on 11/6/24 at 1:40 PM, Certified Nurse Aide #7 stated they did not clean Resident #96's fingernails, they should have cleaned them during morning care because Resident #96 had debris under their nails, and they ate some foods with their hands. Certified Nurse Aide #7 stated they did not know what was under Resident #96's fingernails. They stated bacteria could be under the fingernails and they should have been cleaned before eating their breakfast. During an interview on 11/8/24 at 8:11 AM, Licensed Practical Nurse #7 stated it was the certified nurse aides and the nurse's responsibility to make sure residents fingernails were trimmed and cleaned because it was just part of care. They stated fingernails should be cleaned every day and whenever they were dirty. During an interview on 11/8/24 at 8:16 AM, the Assistant Director of Nursing/Infection Preventionist stated Resident #96's fingernails should have been cleaned when Certified Nurse Aide #7 saw they needed to be cleaned during morning care because it was general hygiene. During an interview on 11/8/24 at 11:37 AM, the Director of Nursing stated they expected nail care to be completed on shower days and/or as needed. The Director of Nursing stated Resident #96 should have had their nails cleaned if they needed it, during morning care and prior to receiving breakfast. They expected nails to be kept clean for dignity and cleanliness. 10 NYCRR 415.12 (a)(3)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during the Standard survey completed on 11/8/24, the facility did not ensure that residents who had an indwelling (foley) catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for two (Residents #27 & #53) of three residents reviewed. Specifically, there was a lack of a urology follow- up following a cystoscopy (diagnostic test to inspect the interior lining of the bladder and urethra), and a foley leg bag was not used during day time hours as planned (#53); and infection control practices were not maintained (#27 & #53). In addition, staff inaccurately documented the placement of the foley leg bag in the treatment record (#53). The finding is: The policy and procedure titled Process for Scheduling Outside Appointments, revised 6/24, documented the facility will assist the resident in gaining access to specialty providers per their preference and per provider recommendations when needed for the resident's health and well-being. The facility will assist residents and their representatives in locating and utilizing any available resources the resident needs. Resident appointments will be scheduled with assigned provider per provider recommendation and resident request. An order for appointment to be placed in the electronic medical record/designated location. Nursing to communicate to the unit clerk/designee that there is an order for requested appointment. Unit clerk/designee to schedule an appointment based on the order, medical necessity, cognitive status, and mode of transportation. Resident and family will be made aware of the status of the appointment. The policy and procedure titled Catheter Drainage Bag Care: Urinary, revised on 5/13, documented the catheter and tubing must remain patent, with the drainage bag kept below the level of the bladder, to maintain unobstructed urine flow and prevent pooling and backflow of urine into the bladder. Care should be taken to make sure the tubing does not touch or drag on the floor. Drainage leg bags may be used to allow residents who require an indwelling catheter, more dignity and independence while out of bed. 1. Resident #53 had diagnoses which included severe sepsis (a severe blood infection), urinary tract infection, and bladder outlet obstruction (abnormal urine flow). The Minimum Data Set (a resident assessment tool) dated 9/4/24, documented Resident #53 had cognitively intact, was understood, and understands. Resident #53 had an indwelling foley catheter. The undated comprehensive care plan documented Resident #53 had a urinary catheter. Interventions included to monitor for signs and symptoms of a urinary tract infection, and to wear a urinary leg bag during daytime hours. Additionally, the care plan included annual urology consults. The Visual/Bedside Kardex (guide used by staff to provide care) dated 8/13/24 and verified by Licensed Practical Nurse Unit Manager #2 as current documented to provide urinary catheter care every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Hospital Discharge Summary dated 6/4/24, documented severe sepsis secondary to urinary retention, bladder outlet obstruction, and urinary tract infection. The Hospital Discharge Summary further documented to continue the foley catheter and follow up with urology. Review of the Order Summary Report dated 7/31/24 documented an active physician's order to apply a foley leg bag in the morning and remove at bedtime with a start date of 8/2/24 and there was no end date. In addition, there were no physician's orders for a urology consult. a. Review of the cystoscopy operative note dated 8/2/24 documented Resident #53 was discharged back to the facility with a foley catheter and required follow up as an outpatient for further management of urinary retention. The medical provider's Interval Note dated 8/14/24 documented Resident #53 had a cystoscopy on 8/2/24 and required a foley catheter for obstructive uropathy. Medical Provider #1 documented that Resident #53 needed to follow up with the urologist. Progress Notes date 8/14/24 completed by Medical Records Assistant #2 documented they arranged transportation and a urology follow up from the cystoscopy on 8/2/24. The appointment was scheduled for 9/12/24 at 3:15 PM. Review of the Nursing Progress Notes on 9/12/24 revealed no documented evidence that Resident #53 attended the urologist appointment, or the appointment was missed or rescheduled. During a telephone interview on 11/6/24 at 11:40 AM, Reception Supervisor #1 at the urology clinic stated they had phoned the nurse on the unit at the facility on 9/11/24 that Resident #53's appointment was rescheduled from 9/12/24 at 3:15 PM to 9/18/24 at 10:15 AM and couldn't recall which nurse they had spoken with. Resident #53 was a no show on 9/18/24. The facility never followed up on the missed appointment. Review of the [NAME] Unit twenty-four-hour report sheets dated 9/11/24 through 9/18/24 revealed there was no documented evidence that Resident #53's urology appointment was rescheduled to 9/18/24. There was no documented evidence that Resident #53 attended the scheduled urology appointment on 9/18/24. During an interview on 11/7/24 at 9:39 AM, Medical Provider #1 Medical Provider #1 stated Resident #53 missed their appointment due to transportation issues on 9/12/24 and was not a big deal. The treatment would not have changed. During an interview on 11/7/24 at 9:40 AM, Licensed Practical Nurse Unit Manager #2, stated appointment/transportation sheets were filled out by the nurse then given to medical records for outside appointments. The sheets included the date, time, location, the transportation company, and whether an escort was needed. Medical Record Assistant #1 emailed a monthly list and tracked appointments. Revisions were emailed weekly. During a telephone interview on 11/8/24 at 10:05 AM, Medical Records Assistant #2 stated they were unaware the 9/12/24 appointment was rescheduled to 9/18/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/08/24 at 12:23 PM, the Director of Nursing, in the presence of the Administrator, stated appointment/transportation sheets were not included in their process. Medical records arranged out of the facility appointments and the facility needed to improve their process. b. During an observation on 11/5/24 at 2:56 PM, Resident #53's foley catheter drainage bag was contained in a privacy bag under their wheelchair. The resident was not utilizing a urinary leg bag as planned. Review of the Treatment Administration Record on 11/5/24 at 3:00 PM Revealed Licensed Practical Nurse #1 initialed the foley leg bag was applied on the 7:00 AM -3:00 PM shift. During an observation and interview on 11/6/24 at 10:05 AM eight inches of the catheter tubing, containing yellow urine, and was lying on the floor under Resident #53's wheelchair. The resident was not utilizing a urinary leg bag as planned. Resident #53 stated they preferred the leg bag and was more comfortable. During an interview on 11/6/24 at 10:28 AM, Certified Nurse Aide #2 stated catheter tubing should be kept off the floor and Resident #53 should have had their leg bag on. During an observation and interview on 11/6/24 at 10:33 AM, Certified Nurse Aide #1 stated the urinary catheter tubing should not touch the floor. They had a hard time stuffing and securing the tubing into the privacy bag. At 10:35 AM Certified Nurse Aide #1 cleaned the catheter tubing with an alcohol swab and then placed the catheter tubing onto the floor and stated while exiting Resident # 53's room, nurses applied foley leg bags. During an interview on 11/6/24 at 10:36 AM, Licensed Practical Nurse #1 stated they had seen the catheter tubing on the floor earlier this morning, signed they had applied the leg bag on the treatment administration record and forgot to apply the leg bag. They stated the leg bag provided dignity and comfort. Licensed Practical Nurse #1 stated the catheter tubing on the floor was an infection risk and Resident #53 was prone to infection. During an observation and interview on 11/6/24 at 10:40 AM, Licensed Practical Nurse Unit Manager #2 stated bacteria on the tubing from the dirty floor could cause infection and was inappropriate. Licensed Practical Nurse #1 should have applied the leg bag before they got Resident #53 out of bed, they should sign off the treatment administration record after the leg bag was on. They stated the leg bag reduced the risk of infection. During an interview on 11/7/24 at 9:39 AM, Medical Provider #1 Medical Provider #1 stated as a preventative infection control measure the foley catheter tubing should not be on the floor. c. Review of the physician's telephone orders dated 11/6/24 revealed Medical Provider #1 ordered Resident #53 a chest x-ray, complete blood count with differential and complete metabolic profile (blood work), a urinalysis, and culture and sensitivity (urine diagnostic test). Vital signs were ordered every four-hours for forty-eight hours. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/24 at 8:45 AM Resident #53 stated they felt shaky, chilled, and off, and on 11/6/24 they were given an antibiotic for a urinary tract infection. During an interview on 11/7/24 at 10:08 AM, Licensed Practical Nurse, Unit Manager #2 stated Resident #53 displayed mild confusion and lethargy, so Medical Provider #1 ordered a urinalysis and culture and sensitivity. The Order Summary Report dated 11/7/24 documented an active physician's order for Ceftriaxone Sodium Solution (antibiotic) Reconstituted 1 gram. Inject 2.8 cubic centimeter (cc) intramuscularly one time a day for urinary tract infection until 11/8/24. Review of the 11/2024 Medication Administration Record revealed Resident #53's urine specimen was collected on 11/6/24 and one dose of Ceftriaxone Sodium Solution reconstituted 1 gram was administered as ordered for a possible urinary tract infection. Lab Results Report collected 11/6/24 and received on 11/7/24 documented the urinalysis with microscopic reflex showed a large amount of leukocyte esterase (enzyme indicative of infection). During an interview on 11/8/24 at 11:22 AM, the Assistant Director of Nursing/ Infection Preventionist stated Resident #53 was at risk for urinary tract infections. Certified Nurse Aide #1 should have secured the clean catheter tubing in the privacy bag and to avoid contamination. The Assistant Director of Nursing/ Infection Preventionist expected residents to wear leg bags when out of bed unless they refused. During an interview on 11/8/24 at 11:32 AM, Medical Provider #1 stated Resident #53 complained of being chilled on 11/6/24 and covered them with a few doses of antibiotics due to Resident #53's susceptibility to urosepsis. Resident #53 was symptomatic for a urinary tract infection. During an interview on 11/08/24 at 12:23 PM, The Director of Nursing, in the presence of the Administrator, stated the foley leg bag would have prevented the tubing from lying on the floor and did not think the tubing on the floor contributed to the current urinary tract infection. Licensed Practical Nurse #1 should have applied the leg bag then signed the treatment administration record. 2. Resident #27 had diagnoses that included hydronephrosis with renal and ureteral calculous obstruction (enlargement of the kidney due to blockage), chronic kidney disease stage 3, and history of urinary tract infections. The Minimum Data Set, dated dated dated [DATE], documented Resident #27 had moderate cognitive impairment, was understood and understands. Resident #27 had an indwelling foley catheter. The undated Visual/Bedside Kardex documented Resident #27 required a moderate assist of 2 staff members with a sit to stand lift for toileting and to offer incontinent care every 2-3 hours. The Visual/Bedside Kardex documented Resident #27 required foley catheter care every shift. The current comprehensive care plan documented staff were to encourage fluid intake and to monitor Resident #27 for symptoms of a urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/05/24 at 8:44 AM, Resident #27 was sitting in their wheelchair next to the bed. An empty black privacy bag was hanging off the bottom of the wheelchair. The foley catheter drainage bag was lying directly on the floor along with 6-8 inches of tubing, underneath the resident's wheelchair. The room had a strong odor of urine. At 9:50 AM, the foley catheter drainage bag was hanging from the left arm rest of their wheelchair and was positioned above the level of their bladder. During an interview on 11/7/24 at 12:27 PM, Licensed Practical Nurse Unit Manager #4 stated they were not aware Resident #27's foley catheter drainage bag had been on the floor, but they saw Resident #27's foley catheter drainage bag hanging on the side of their wheelchair arm rest on 11/5/24. Licensed Practical Nurse #4 stated foley catheter drainage bags should always be below the level of the bladder and be in a privacy bag, never on the floor or hanging from a wheelchair arm rest. Licensed Practical Nurse #4 stated the Nurses and Certified Nurse Aides were responsible for ensuring foley catheter drainage bags were placed appropriately to prevent back flow and infections. Additionally, Licensed Practical Nurse #4 stated Resident #27 had a history of urinary tract infections. During an interview on 11/7/24 at 12:29 PM, Certified Nurse Aide #6 (assigned to resident on 11/5/24) stated they were unaware Resident #27's foley catheter drainage bag was on the floor or hanging from their arm rest on 11/5/24. Certified Nurse Aide #6 stated appropriate placement of foley catheter drainage bags was important for infection and sanitary reasons. During an interview on 11/08/24 at 11:22 AM, the Assistant Director of Nursing/ Infection Preventionist stated there was a risk for infections, specifically urinary tract infections, if foley catheter drainage bags were left lying on the floor or positioned above the level of the bladder. The Assistant Director of Nursing/Infection Preventionist stated their expectations would be for foley catheter drainage bags to be in a privacy bag with tubing off the floor, below the level of the bladder. The Assistant Director of Nursing/Infection Preventionist stated all nursing staff were responsible for ensuring appropriate placement of foley catheter drainage bags. During an interview on 11/8/24 at 12:23 PM, the Director of Nursing, in the presence of the Administrator, stated foley catheter drainage bags should be in a privacy bag and not on the floor, as it could lead to a possible infection. The Director of Nursing stated foley catheter drainage bags should never be above the level of the bladder. The urine would flow back into the bladder and could lead to a bladder infection. The Director of Nursing stated all staff were responsible to ensure foley catheter drainage bags and tubing are placed appropriately. 10NYCRR 415.12 (d) (2)