STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335527	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd-Fairview Home Inc	80 Fairview Avenue Binghamton, NY 13904

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview during the recertification survey conducted 7/29/2025-8/1/2025, the facility did not develop care plans that describe the resident's medical, nursing, physical, mental and psychosocial needs and preferences and how the facility will assist in meeting these needs and preferences for (4) of four (4) residents (Residents #65, #4, #8, and #5) reviewed. Specifically, Resident #65 and #4's care plan did not include the use of anticoagulant (blood thinner) medication. Resident #8's care plan did not include the use of diabetic medications and Resident #5's care plan did not include the use of antihypertensive medications. Findings include: The facility policy, Comprehensive Care Plan, revised 7/2019, documented each discipline was responsible for the initiation and augmentation of problems with correlating goals and approaches to address care areas, to support the highest quality of care. Interdisciplinary team members were expected to have analyzed each triggered care area assessment related to their discipline and would have made care planning decisions based on their professional judgment. The care manager was responsible for collaboration with the interdisciplinary team, gathered input from the resident and direct care staff, and would have entered the information into the care plan. 1) Resident #65 had diagnoses including atrial fibrillation (irregular heartbeat), and coronary artery disease. The 7/29/2025 Minimum Data Set assessment documented the resident's cognition was intact, required minimal assistance for most activities of daily living, and was to be discharged home following rehabilitation. The physician orders dated 7/25/2025 through 8/31/2025 documented Eliquis (anticoagulation/blood thinner) 5 milligrams two times a day for an irregular heartbeat. The admission history and physical dated 7/29/2025 Medical Doctor #6 documented the resident had a significant cardiac history which Included atrial fibrillation, coronary artery disease, history of cardiac stent placements and implanted cardiac defibrillator. The resident was to have continued all cardiac medications including, aspirin and Eliquis and continued with iron supplementation related to the resident's anemia. The comprehensive care plan initiated 7/29/2025, documented the resident was at risk for falls. Interventions included education the resident on fall risks. The comprehensive care plan did not include the resident's use of anticoagulant medication. The undated care card did not include any documentation related to the resident's use of anticoagulant medication. During an observation and interview on 7/29/2025 at 2:51 PM, Resident #65 stated they had (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spontaneous nose bleeds as a result of having been on a blood thinner. During an interview on 8/1/2025 at 10:05 AM, Certified Nurse Aide #16 stated would have known if a resident had been on blood thinners by looking at the care card in the computer and by morning report. They had not been aware of resident #65 having been on a blood thinner. They had not witnessed the resident having had a nosebleed however stated they would have reported it to the nurse as soon as it happened. During an interview on 8/1/2025 at 10:25 AM, Licensed Practical Nurse #15 stated they had not been aware of any nosebleeds that resident #65 may have had. The certified nurse aides would have let us know if there was any significant incident such as a bleed. The resident was on blood thinners and the certified nurse aides would know that by looking at the electronic care card. Licensed Practical Nurse #15 reviewed the resident's medical record and stated the resident did not have care plan regarding anticoagulation use. The information contained on the care card came from the care plan. During an interview on 8/1/2025 at 3:10 PM Licensed Practical Nurse Unit Manager #14 stated they were responsible for initiating care plans. If the care plan had been missing pertinent content, the care card would not have had the information either. All nursing staff were educated on the complications related to blood thinners and the importance of observations of the resident. They did not know why there was no anticoagulation care plan developed for Resident #65. 2) Resident #4 had a diagnosis including anemia, hypertension, atrial fibrillation and a left hip fracture. The 6/2025, Minimum Data Set documented the resident had a moderate cognitive impairment, used both a walker and a wheelchair, required a moderate amount of assistance with most activities of daily living, and received anticoagulant medication. The undated certified nurse aide care card identified the resident was a fall risk. There was no information related to anticoagulation. A progress note on 6/23/2025 by Nurse Practitioner #12 documented the resident had returned to the facility following an unwitnessed fall with a head strike the previous day. Testing revealed no acute cranial hemorrhage or skull fracture. The resident was evaluated upon their return to the facility, and the staff had been updated on the plan of care and instructed to continue safety interventions. The comprehensive care plan last revised on 6/25/2025 identified the resident was a high risk for falls and they were unaware of their safety needs. There was no documentation within the care plan indicating that the resident had been receiving anticoagulant therapy. The physician's order on 7/25/2025 documented the resident was to continue to receive Apixaban (blood thinner) 2.5 milligram tablets twice daily for anticoagulation. During an interview on 8/11/2025 at 4:04 PM the Director of Nursing stated the managers would have been responsible to have initiated and updated the care plans. The supervisors would have also updated them as needed. The care plans would have been reviewed every quarter, every new problem, every medication change, or every time there had been a gradual dose reduction. There should be a care plan for anticoagulation medications because the resident would have been monitored for bruising or bleeding. It was the expectation to have a care plan for diabetic as well as any hypertensive medication. Director of Nursing stated if the resident had been treated for something it would have been on the care plan. The care was what directed the residents care and informed the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff on how to care for that resident. 3) Resident #5 had diagnoses including hypertension, peripheral vascular disease (narrowed or blocked blood vessels in limbs), and dementia with other behavioral disturbance. The 5/25/2025 Minimum Data Set documented the resident was severely cognitively impaired, had behaviors, rejected care, and had a diagnosis of hypertension. The resident had no documented care plan related to their diagnosis of hypertension or their hypertensive medications. The 5/29/2025 physicians orders documented the resident received one tablet of 2.5 milligrams of Amlodipine Besylate by mouth one time a day for hypertension and two tablets of 75 milligrams of irbesartan one time a day for hypertension. The irbesartan was to be held if the resident's systolic blood pressure was less than 130. The July 2025 Medication Administration Record documented the resident received their medication as ordered for the month of July. During an interview on 8/1/2025 at 1:45 PM, Licensed Practical Nurse #11 stated residents on hypertension medication were to have their blood pressure and pulse monitored. There were also orders with specific parameters regarding the blood pressure medication they received. The resident's care plan for their hypertension had all of their symptoms the resident experiences so the staff knew what to look for in a hypertensive episode. During an interview on 8/1/2025 at 1:57 PM, Licensed Practical Nurse Unit Manager #14 stated residents on hypertensive medications had cardiac care plans related to their hypertension and medication. Resident #5 did not have a cardiac care plan, and they should have one. The care plan must have been missed. During an interview on 8/1/2024 at 4:04 PM, the Director of Nursing stated the Nurse Managers were responsible for initiating and updating care plans. Care plans were reviewed quarterly at minimum but also with medication changes and new problems. Residents who were on hypertensive medications should have a cardiac care plan. If the resident was being treated for something, there should be a care plan in place to tell staff how to care for that resident. 10NYCRR 415.11(c)(2)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review during the recertification survey conducted 7/29/2025 to 8/1/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection for one (1) of two (2) residents (Resident #5) reviewed. Specifically, Resident #5's enhanced barrier precautions were not followed, and wound care was completed without appropriate hand hygiene, clean supplies, and precautions to prevent contamination of the wound. Additionally, Licensed Practical Nurse #15 did not perform hand hygiene consistently during their medication administration between residents.Findings included: The facility policy Enhanced Barrier Precautions, revised 11/2024, documented enhanced barrier precautions were utilized to prevent the spread of multidrug-resistant organisms to residents. Gowns and gloves were to be utilized during high contact resident care activities when contact precautions did not apply. Examples of high contact resident care activities included wound care. Enhanced barrier precautions were indicated for residents with wounds when contact precautions did not apply and remained in place until the resolution of the wound. Staff are trained prior to caring for residents on enhanced barrier precautions and signs were posted at the resident's room indicating the type of precautions and personal protective equipment required.The facility policy Medication Administration-General Guidelines, effective 4/2022, documented hand hygiene must be performed before and after medication administration.Wound Care:Resident #5 had diagnoses including peripheral vascular disease (narrowed or blocked blood vessels in limbs) and hypertension. The 5/25/2025 Minimum Data Set (MDS) assessment documented the resident's cognition was severely impaired, had one unstageable pressure injury, and one veinous or arterial ulcer.The Comprehensive Care Plan initiated 6/28/2021, updated7/29/2025, documented the resident had potential for skin breakdown related to hypertension, impaired cognition, and impaired mobility. The resident had a left second toe peripheral vascular wound that opened 1/26/2025, a deep tissue injury to the right posterior heel that occurred on 1/27/2025 and was on enhanced barrier precautions related to a chronic wound.The 6/25/2025 physician's order documented to apply skin prep to the left second toe every day shift for a vascular wound.The 7/16/2025 physician's order documented to cleanse the right posterior heel with wound wash, apply Adaptic dressing to wound base and cover with Optiform once daily every dayshift for wound care.The 7/29/2025 physician's order documented the resident was on enhanced barrier precautions for chronic wounds.During a wound care observation on 7/31/2025 at 10:00 AM, Licensed Practical Nurse #21 wrote the order for Resident #5's wound care on a sticky note then obtained the wound care supplies from the treatment cart in the medication room without performing hand hygiene or gloving. The treatment supplies included a skin prep packet, unpackaged gauze squares, a package of Adaptic non-adhesive dressing, a bottle of wound wash dated 7/1/2025, an optifoam heel protector, tape and an unpackaged gauze roll. All supplies were set on top of the unprotected treatment cart surface while they grabbed gloves which were placed in the pocket of the licensed practical nurses' uniform top. The supplies were carried to the resident's room with an ungloved hand and set down on an unprotected and uncleaned nightstand. The unpacked gauze was directly touching the nightstand, and the scissors were on top of the sticky note also placed on the nightstand. Licensed Practical Nurse #21 washed their hands in the bathroom and then kneeled in front of the resident while they were sitting in their wheelchair and took the resident's sock off their right foot. Licensed Practical Nurse #21 then put gloves on, moved the paper towels they had obtained from the bathroom and the wound care supplies and placed them on a chair behind them. The paper towels were then moved to the floor under the resident's heel with the wound care supplies remaining on the chair. Licensed Practical Nurse #12 removed the resident's previous dressing from their heel and then lifted the heel to look at the resident's wound. They did not change their gloves or sanitize their hands after removing the dirty dressing. They grabbed the unwrapped gauze square and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sprayed it with wound wash and held it against the wound. All other wound care supplies (the package of Adaptic with scissors on top and unpacked gauze wrap) were then placed on the floor without a barrier next to the paper towels under the resident's foot and the pile of the previous dirty dressing. Licensed Practical Nurse #21 then cut the multi-use Adaptic square with uncleaned scissors, placed the rest of the Adaptic dressing back in its package, placed the scissors directly onto the uncleaned chair behind them, and applied the cut Adaptic piece to the resident's wound, applied Optifoam heel protector and then wrapped with the unpackaged gauze roll. The gauze roll was then cut to length with uncleaned scissors. Licensed Practical Nurse #21 put the resident's sock and slipper back on without removing or changing their gloves or performing hand hygiene. The resident's left slipper and sock were removed, and skin prep was applied to the resident's left second toe, then their sock and shoe replaced without Licensed Practical Nurse #21 changing their gloves or performing hand hygiene. Licensed Practical Nurse #21 then threw all the used/dirty supplies away, removed their gloves, put the uncleaned scissors into their uniform top pocket, and brought the resident out to the common area with the bottle of wound wash and multi-use Adaptic package in the hand. They then put the wound wash and Adaptic package back into the treatment cart in the medication room then went to the common area to wash their hands. They had not put on personal protective equipment per the resident's enhanced barrier precaution at all during the wound care.During an interview on 7/31/2025 at 10:14 AM, Licensed Practical Nurse #21 stated the process for providing wound care was to check the order, gather the supplies, wash their hands, put on gloves, then perform the treatment. Residents who had wounds were on enhanced barrier precautions as the resident was at risk of higher levels of infection. Enhanced Barrier Precautions meant gowns, gloves, and masks needed to be worn when in the room. They forgot the resident was on Enhanced Barrier Precautions when the performed the resident's wound care. Wound care items should not be placed on uncleaned surfaces or surfaces without a barrier. They should not have placed the wound care supplies on the non-sanitized bedside table, chair, or floor. They should have changed their gloves and sanitized their hands after removing the soiled dressing and putting on the new dressing. They did not know why they did not. They should have sanitized their hands after wound care prior to returning the multiuse items to the clean treatment cart.During an interview on 8/1/2025 at 10:24 AM, Licensed Practical Nurse Unit Manager #14 stated if a resident was on Enhanced Barrier Precautions the staff should be wearing a gown and gloves for wound care. Wound care supplies should not be placed on an uncleaned, uncovered surface or on the floor. Multiuse Adaptic dressing should not be cut with uncleaned scissors and hand hygiene and glove changing should be performed in-between removing the soiled dressing and placing the new dressing. Gloves should be changed and hand hygiene performed after removing a resident's shoes and socks prior to doing wound care. Hand hygiene should also be performed prior to bringing multiuse wound care supplies back to the treatment cart.During an interview on 8/01/2025 at 2:47 PM, the Infection Preventionist stated when a resident was on enhanced barrier precautions their name tag on their door was flipped to the orange side, a personal protective equipment cart was placed in their room and the precaution sign was hung up. The resident and their family were also educated on why they were on it and what to do. A resident with wounds would be put on enhanced barrier precautions. Staff should be putting on gowns and gloves to care for a resident with an open wound as they are in direct contact with the area the resident was placed on precautions for. All staff were just recently educated within 2025 on enhanced barrier precautions and the nurses had competencies done on infection control and precautions. Gloves should be changed, and hand hygiene should be performed after removing the old dressing before applying the new one. Wound care supplies should not be placed on unclean surfaces, there should always be a barrier, and the surfaces should be wiped down. Wound care items should not be placed on the floor. Uncleaned scissors should not be used to cut multiuse Adaptic dressings.Hand Hygiene during Medication Administration:During a medication administration observation from 12:41 PM to 1:52 PM, Licensed Practical Nurse #15 administered medications to Residents #36, 39, 47, 66, and 67 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without performing hand hygiene between residents.During an interview on 7/30/2025 at 2:06 PM, Licensed Practical Nurse #15 stated they did not remember to wash their hands between residents during medication administration. They stated they often got into a rush and forget to perform hand hygiene. During an interview on 8/01/2025 at 2:47 PM, the Infection Preventionist stated hand hygiene should be performed during medication administration. The licensed practical nurses should at least be wearing gloves for each administration and using hand sanitizer between each resident.10 NYCRR 415.19

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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. Based on observation, record review, and interview during the recertification survey conducted 9/9/2024-9/16/2024, 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 resident's choices for one (1) of one (1) resident (Resident #8) reviewed. Specifically, Resident #8's diabetes mellitus diagnoses was incorrect in the resident's electronic medical record and was incorrectly coded in their Minimum Data Set, their morning insulin sliding scale order was not updated timely per the Endocrinologist's recommendation, the resident had a low blood sugar outside their sliding scale parameters with no documented notification to the provider, did not have maximum parameters on their sliding scales on when to notify the provider, and did not have a person-centered diabetic management care plan. Additionally, the resident did not have the recommended diabetic eye exam scheduled. The facility policy, Emergency Procedure Hyperglycemia, effective 4/2022, documented the nurse was to perform a finger stick and determine the blood sugar level with the glucometer. The nurse was to check for sliding scale insulin orders/parameters, follow the orders as written, and notify the registered nurse, nurse practitioner, and the physician would determine if 9-1-1 needed to be called. The nurse was to prepare the insulin per the medical provider's order and secure vital signs as soon as possible and every 10-15 minutes until stable.The facility policy, Interdisciplinary Comprehensive Care Plan, effective 4/2022, a comprehensive care plan must be completed within the first 7 days after admission that include person-centered, measurable objectives and timetables to meet resident's medical, nursing, mental, and psychosocial needs. Members of the interdisciplinary team were to update the comprehensive care plan as needed and review on no less than a quarterly basis.Incorrect diagnosis and Minimum Data Set coding and Care plan: Resident #8's electronic medical record documented the resident had diagnoses including Type 2 diabetes mellitus with hyperglycemia (high blood sugar), Type 2 diabetes mellitus with diabetic neuropathy (nerve damage), and hypertension (high blood pressure). The 7/10/2025 Minimum Data Set documented the resident was cognitively intact, the resident had Type 2 diabetes mellitus and received daily insulin with changes.There was no documented diabetes mellitus plan of care.The 4/17/2025 Endocrinology Office Note by Nurse Practitioner #3 documented Resident #8 had been diagnosed with Type 1 diabetes following pancreatitis in 2006.The 6/18/2025 Physician's Progress Note by Medical Provider #6 documented the resident had a diagnosis of Type 1 Diabetes Mellitus. During an interview on 8/01/2025 at 10:24 AM Licensed Practical Nurse Unit Manager #14 stated the resident was a Type 1 diabetic, the resident should have a diabetic/insulin care plan. The resident did not have one, it must have been missed.During an interview on 8/1/2024 at 4:04 PM, the Director of Nursing stated the Nurse Managers were responsible for initiating and updating care plans. Care plans were reviewed quarterly at minimum but also with medication changes and new problems. Residents who were diabetic and on insulin should have a care plan to reflect that. Care plans direct a resident's care to let staff know how to care for the resident.Diabetic eye care follow up:The 4/17/2025 Endocrinology Office Note by Nurse Practitioner #3 documented they recommended the resident have an updated diabetic eye exam as part of their plan of care for the management of their Type 1 Diabetes Mellitus.The 4/17/2025 After Visit Summary from Endocrinology documented Nurse Practitioner #4 recommend that the resident have a yearly diabetic eye exam and request the facility to assist to schedule.There was no documented evidence a diabetic eye exam was completed or scheduled for the resident.During an interview on 8/1/2025 at 11:07 AM, Unit Secretary #13 stated they had not scheduled a diabetic eye exam for Resident #8. They were unaware of the recommendation from the Endocrinologist on 4/17/2025. They had not seen it when they reviewed the paperwork.Timely sliding scale order change:The 5/28/2025 physician's order Humalog subcutaneous injection per sliding scale: if the resident's blood sugar was 90 - 160 = inject 8 units subcutaneously; 161 - 200 = 10 units; 201 - 250 = 12 units; 251 - 300 = 12 units; 301+ = 14 units at 7:00 AM. The order was discontinued on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/7/2025.On 7/1/2025, Nurse Practitioner #3 from the Endocrinologist office reviewed the blood sugar logs for Resident #8 and noted the blood sugars before lunch were elevated and the Nurse Practitioner recommended increasing the sliding scale insulin at breakfast by 2 units. On 7/2/2025, a new morning sliding scale was faxed to the facility that included Humalog insulin for blood sugar 90 - 160 = inject 10 units subcutaneously; 161 - 200 = 12 units; 201 - 250 = 14 units; 251 - 300 = 14 units; 301+ = 16 units.There was no documented evidence the recommended new sliding scale from the endocrinologist office was addressed until 7/8/2025. The resident's morning blood sugars following breakfast prior to lunch between 7/2/2025 to 7/7/2025 were:- on 7/1/2025: 363- on 7/2/2025: 239- 7/3/2025: 169- on 7/4/2025: 338- on 7/5/2025: 280- on 7/6/2025: 478- on 7/7/2025: 329The 7/8/2025 physician's order documented the resident used Humalog subcutaneous injection per sliding scale at 7:00 AM: if the resident's blood sugar was 90 - 160 = inject 10 units subcutaneously; 161 - 200 = 12 units; 201 - 250 = 14 units; 251 - 300 = 14 units; 301+ = 16 units.During an interview on 8/1/2025 at 9:45 AM, Unit Secretary #13 stated when a resident came back from a consult or a consult from an outside provider, the consult paperwork came to the nursing station hub, Licensed Practical Nurse Unit Manager #14 reviewed it and then Unit Secretary #13 scanned it into the chart. If the consult paperwork contained orders, Licensed Practical Nurse Unit Manager #14 reviewed it and then informed the providers of the orders. If Licensed Practical Nurse Unit Manager #14 was not there, the Director of Nursing reviewed the consults.During an interview on 8/01/2025 at 10:24 AM Licensed Practical Nurse Unit Manager #14 stated when consults come back from appointments with residents or were faxed over, they reviewed the consult. If there were orders, they reviewed them with the provider within 24 hours. On 7/2/2025, they were aware there was a lot of back and forth with the Endocrinologist regarding Resident #8. There was no documentation of contact with the Endocrinologist office or them not receiving the expected sliding scale change on 7/2/2025.During a phone interview on 8/1/2025 at 12:18 PM, Licensed Practical Nurse #4 from the Endocrinologist office stated the facility had called on 7/7/2025 to inform them they had not received the new insulin sliding scale for Resident #8's morning blood sugar check. Licensed Practical Nurse #4 stated the facility had been anticipating the new orders as they had to call the facility to obtain their fax number. During a phone interview on 8/01/2025 at 3:14 PM, Medical Provider #6 stated if the facility staff were aware Endocrinology was sending over new orders for a sliding scale and they did not receive it that day, they should call that day to follow up on not receiving the orders.No parameters for physician notification:The resident's Humalog insulin orders did not contain parameters to instruct the administrating nurse when to notify the provider for blood sugar that were low, high or outside the sliding scale range. The July Medication Administration record documented:- on 7/21/2025 at the 7:00 AM blood sugar check, the resident had a blood sugar level of 72. The resident's insulin was held for being outside parameters. There was no documented evidence the provider was made aware, or steps were taken for the resident's low blood sugar.- on 7/6/2025 at 12:00 PM, 7/9/2025 at 12:00 PM and 5:00 PM, 7/10/2025 at 12:00 PM, 7/23/2025 at 12:00 PM, and 7/27/2025 at 12:00 PM the resident had blood sugars of 400 and over with no documentation of notification to the provider or steps taken except to provide the 301+ insulin coverage from the sliding scale.During an interview on 8/1/2025 at 9:32 AM, Licensed Practical Nurse #11 stated if a resident was on a sliding scale of insulin for diabetes mellitus and a resident's blood sugar were outside the numbers on the sliding scale you had to notify the provider. On 7/21/2025 when Resident #8's blood sugar level was 72, they notified the Nurse Practitioner #12 who was rounding on the floor. They were also supposed to give orange juice if a resident's blood sugar was below 100. They had not documented notifying Nurse Practitioner #12 or that they gave the resident orange juice. There were no additional orders for the resident besides giving orange juice to Resident #8. If the resident's sugar was low, the resident had their own designated glucagon in the medication cart, but they would need an order for when to administer it. During an interview on 8/01/2025 at 10:24 AM Licensed Practical Nurse Unit Manager #14 stated a resident who was on a sliding scale for insulin whose blood sugars were outside of the sliding scale (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse was to notify the provider and themselves as the Unit Manager. It should be documented if the provider was notified. They were unaware Resident #8 had a blood sugar of 72 on 7/21/2025 and it was something they should have been aware of. Resident #8 did not have an order to notify the provider if their blood sugar reached above a certain number; it was based on clinical judgement. If Resident #8 had a blood sugar of 458, the provider should have been notified.During a phone interview on 8/01/2025 at 3:14 PM, Medical Provider #6 stated if a resident was on sliding scale insulin orders, there was supposed to be parameters for when the nursing staff were to call the physician. If it was above a certain number, they were to call a physician. They believed for the facility it was if the resident's blood sugar was above 300 or 350. They were unaware of what the facility's protocol was for at which low threshold the nursing staff was to notify the physician. They expected a sliding scale order to have parameters for when to call the provider. They were unaware Resident #8 had four sliding scales that did not have parameters and there should be. They stated if a resident had a blood sugar of 478, the facility staff should notify a provider as the resident might need more insulin.10NYCRR 415.12

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	335527	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd-Fairview Home Inc	80 Fairview Avenue Binghamton, NY 13904

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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 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. Based on record review, observations, and interviews during the recertification survey conducted 7/29/2025 - 8/1/2025, the facility did not ensure a resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection and prevent new ulcers from developing for one (1) of two (2) residents reviewed (Resident #5). Specifically, Resident #5 had a pressure ulcer that was not reclassified to its proper stage once opened and they did not have their ordered protective dressing applied to their hand as ordered to maintain skin integrity. Additionally, the resident's privacy was not maintained during wound care. The facility policy, Skin-Wound Assessment and Care, effective 4/2022, documented the interdisciplinary team were to minimize pressure and risk factors to the resident's skin and ensure adequate hydration and nutrition to maintain skin integrity. A pressure ulcer means an ulcer and/or necrotic tissue overlaying a bony prominence that had been subjected to pressure, friction, or sheer. The nurse would observe the resident for skin care needs, including preventative measures. Preventative measures as recommended in the [National Pressure Ulcer Advisory Panel] prevention and treatment of pressure ulcer guidelines on any resident at risk for skin breakdown.The Minimum Data Set 3.0 Resident Assessment Instrument Manual, effective 10/2024, documented a deep tissue injury was defined as a purple or maroon area of discolored intact skin due to damage of underlying soft tissue. Once deep tissue injury has opened to an ulcer, the ulcer was to be reclassified into the appropriate stage.Resident #5 had diagnoses including peripheral vascular disease (narrowed or blocked blood vessels in limbs), dementia with other behavioral disturbance, and hypertension. The 5/25/2025 Minimum Data Set documented the resident was severely cognitively impaired, had an impairment to both left and right upper and lower extremities, was at risk for developing pressure ulcers, and had one unstageable pressure injury that presented as a deep tissue injury.The Comprehensive Care Plan initiated 6/28/2021, updated 7/29/2025, documented the resident had potential for skin breakdown related to hypertension, impaired cognition, impaired mobility. The resident had a left second toe peripheral vascular wound that opened 1/26/2025, a deep tissue injury to the right posterior heel that occurred on 1/27/2025, was on enhanced barrier precautions related to a chronic wound and was ordered to have a small Allevyn Ag Gentle Border Adhesive dressing to right palm for preventative. The 2/10/2025 Physician's order documented to apply small Allevyn Ag Gentle Border Adhesive dressing to the right palm once every other day and as needed for preventative.The 7/16/2025 Physician's order documented to cleanse the right posterior heel with wound wash, apply Adaptic dressing to wound base and cover with Optiform once daily every dayshift for wound care.The 6/18/2025 Skin and Wound note by Registered Nurse #17 documented the resident was followed for a deep tissue injury to the right posterior heel and a peripheral vascular wound to the left second toe. The deep pressure injury to the right posterior heel measured 0.5 centimeters by 1 centimeter. It had an odor but no drainage, undermining, or sinus tract. The wound base was pale with a red peri-wound, and a well-defined wound edge. The treatment to the right posterior heel was changed on 6/12/2025 to cleanse area with wound cleanser, pat dry, apply iodosorb on a dry 2 by 2-inch pad, and apply to the wound base. Cover the area with a heel cup and secure with conforming gauze to be changed every day and as needed.The 7/16/2025 Skin and Wound note by Registered Nurse #17 documented the deep tissue injury to the right posterior heel measured 0.9 centimeters by 1.2 centimeters by 0.1 centimeters. There was a scant amount of serous (clear watery fluid) with no odor, undermining, or sinus tract. The wound base was 50 percent red and 50% tendon.The 7/23/22025 Skin and Wound note by Registered Nurse #17 documented the deep tissue injury to the right posterior heel measured 0.7 centimeters by 1 centimeter by 0.1 centimeter. There was a scant amount of serous drainage with no odor, undermining, or sinus tract. The wound base was 80 percent glistening white tendon and 20 percent red. The peri-wound was pink and the wound edge well defined.During observations on 7/29/2025 at 3:17 PM, 7/30/2025 at 1:14 PM, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/31/2025 at 8:21 AM and 1:34 PM, and 8/1/2025 at 9:29 AM the resident's fingers on their right hand were curled in toward the palm and the resident did not have a small Allevyn Ag Gentle Border Adhesive dressing applied.During a wound care observation on 7/31/2025 at 10:08 AM, the resident's wound was a circular wound on the resident's lateral heel approximately the size of a dime with red edges with the tendon line visible with the rest of the wound bed reddish pink with a slightly wet appearance. The door to the resident's room also remained open during wound care and their privacy was not maintained.During an interview on 7/31/2025 at 10:14 AM, Licensed Practical Nurse #21 stated they typically provided privacy such as closing the door or drawing the curtain to provide privacy during wound care for a resident. Resident #5 was very temperamental and can get aggressive during care so they left the door open for if they needed assistance. The resident did not have a privacy curtain in their room since it was a private room. They should have closed the door for privacy. During an interview on 8/1/2025 at 9:32 AM, Licensed Practical Nurse #11 stated treatments and skin integrity intervention orders were documented on the Treatment Administration Record. A resident who had an order for a skin integrity intervention should have it in place as ordered. Resident #5 had an order for a small pad to their right palm ordered every other day and as needed. When they worked with the resident on 7/29/2025, the order was not due that day. The pad should be applied to the resident's hand if it was not there. During an interview on 8/1/2025 at 10:24 AM, Licensed Practical Nurse Unit Manager #14 stated a resident who had a skin integrity intervention ordered should have the device in place. Resident #5 had an order for a small adhesive pad to be applied to the hand to maintain skin integrity. The resident did refuse the pad on occasion, and it should be documented in the electronic medical record as a refusal. They weren't aware of any time the resident had removed the adhesive pad once it was applied. The pad was to relieve pressure on their right hand. They were unaware the adhesive pad had not been applied throughout the week. The resident's deep tissue injury was caused by rubbing from a pair of sneakers the resident had. The wound was considered a deep tissue injury and the staging of the wound was done by Register Nurse #17, who was the Wound Nurse. The deep tissue injury had opened opened up and the wound bed was visible. During an interview on 8/1/2025 at 12:44 PM, Registered Nurse #17 stated they did weekly wound rounds at the facility. They were responsible for staging the wounds if it was a facility acquired wound. If a deep pressure injury opened, they generally kept the classification as a deep tissue injury depending on what the wound base looked like. Resident #5's lateral heel wound was a pressure wound from socks and shoes. They were unsure if since the wound opened if it would still be considered a deep tissue injury but that was what it currently was called. 10NYCRR 415.12(c)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews during the recertification survey conducted 7/29/2025 to 8/1/2025 the facility did not ensure a system of records and accounts of all controlled drugs was maintained for one (1) of two (2) nursing carts (Rehab Unit) reviewed. Specifically, the controlled substance accountability record was not accurately reconciled after the medication was administered to the resident for four residents.Findings include:The facility policy Controlled Medication Storage, effective 5/2018 documented controlled substances were subject to special handling, storage, disposal, and record keeping in accordance with federal, state, and other applicable laws and regulations. A controlled substance accountability record was prepared by the pharmacy/facility for controlled substance category medications including those in emergency supply. The following information was completed on the accountability form upon dispensing or receipt of controlled substance or use of controlled substance from the emergency supply: name of resident, prescription number, name/strength/dose form of the medication, date received, amount received, and name of person who received the medication supply.The facility policy Narcotic and Controlled Drugs Reconciliation/Count, effective 4/2022, documented it was the policy of the facility to reconcile all narcotic and controlled medications reconciliation/count during the shift or at the change of shift on each unit.The facility policy Medication Administration- General Guidelines, effective 4/2022, documented the licensed individual who administered the medication was to record the administration in the medication administration record at the time the medication was given and initial and date the blister pack for the dose administered.During an observation and interview on 7/30/2025 at 10:51 AM with Licensed Practical Nurse #15, four narcotic medications were given to residents and not signed out in the controlled substance accountability record in the nurses' cart for:- Resident #55 had a blister pack for an as needed dose of 10 milligrams of oxycodone that had 9 pills remaining. The count in the controlled substance accountability record was 10. Licensed Practical Nurse #15 stated the medication was given at 10:37 AM.- Resident #26 had a blister pack of 5 milligrams of oxycodone that had 10 pills remaining. The count in the controlled substance accountability record was 11. Licensed Practical Nurse #15 stated they signed for it in the medication administration record when it was given.- Resident #46 had a blister pack of tramadol/apap 37.5-325 milligrams that had two pills remaining. The count in the controlled substance accountability record was 3. The medication was signed for in the medication administration record.- Resident #64 had a blister pack for Percocet that had 13 pills remaining. The count in the controlled substance accountability record was 14. The medication was signed for in the medication administration record as an as needed dose at 9:59 AM.Licensed Practical Nurse #15 stated none of the narcotic medication they have given that morning had been signed out for in the narcotic reconciliation book. They normally signed out when they gave the narcotic medication, but they were very behind that morning. They should be signed for when given so it doesn't look like they took the medication.During an interview on 8/1/2025 at 11:14 AM, the Director of Nursing stated narcotic and controlled medications should be signed out in the narcotic reconciliation book at the time it was given. It was best practice to sign for the medication it was given so its not forgotten to be signed for. When a narcotic or controlled medication wasn't signed for, a concern for diversion of controlled substances occurs.10NYCRR 415.18

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews during the recertification survey conducted 7/29/2025 to 8/1/2025, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for one (1) of two (2) medication carts (Rehab Unit cart) and one (1) of one (1) medication rooms (Rehab Unit) reviewed. Specifically, the Rehab Unit medication cart had three multidose eye drops that were opened and expired. The Rehab Unit medication room had two single resident use medication vials that were unlabeled, there was expired flu vaccine in the medication fridge and a box of medications to be destroyed underneath the medication room sink. Additionally, the Rehab Unit medication cart was left unattended and out of sight of the licensed practical nurse during one observation.Findings include:The facility policy Medication Storage in the Facility, effective 5/2018, documented medications and biologicals would be stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply was to only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully able to administer medications. Medication carts, rooms, and medication supplies were to be locked when unattended. Medications labeled for individual residents were to be stored separately from the floor stock medications when not in the medication cart. Outdated, contaminated, or deteriorated medications and those in containers that have been cracked, soiled, or without secured closures were to be immediately removed from inventory, disposed of in accordance with procedures for medication disposal, and reordered from the pharmacy if there was an active order. Ophthalmic and multiple dose injection vials required an expiration shorter than the manufacturer's recommendation to ensure medication purity and potency. The nurse was to check the expiration date of a medication prior to administration and no expired medication would be administered to a resident.Medication Cart:During an observation and interview with Licensed Practical Nurse #15 on 7/30/2025 at 10:45 AM of the Rehab Unit medication cart there were three eye drop bottles: two bottles of latanoprost 0.005% dated 6/14/2025, one of which had a dose administered out of that morning and one bottle of dorzolamide solution 2% with an open date of 6/14/2025 that a dose was administered from that morning. Licensed Practical Nurse #15 stated eye drops were good for 30 days after opening. All three bottles were expired as they were opened 6/14/2025. They did not know why eye drops were supposed to be given within 30 days. They did not usually look at the open dates on the bottles of eye drops. They stated they were usually in a hurry and residents were not usually on the unit for more than 30 days.During an interview on 08/01/2025 at 11:14 AM, the Director of Nursing stated medication carts were checked at least monthly to ensure there were no expired medications in the cart. Eye drops were labeled on the day it was opened, they were good for 28 days, then they should be disposed of. Eye drops that were opened on 6/14/2025 should not have been given on 7/30/2025 because it was beyond the manufacturer's recommendations to be used after a set amount of time.Medication Room:During an observation and interview on 7/30/2025 at 11:06 AM of the Rehab Unit medication room there was:- two small vials of opened Lidocaine Hydrochloride 1% injection with an open date of 6/30/2025 mixed into the house stock medication bottle cabinet. They were not labeled with the resident's name.- a box of medications and cold packs that were to be destroyed per the Director of Nursing under the sink in the medication room along with a bag full of file folders with paperwork, an empty basin, and an organization tray.- a tube of Secura Protective Cream in the treatment cart that expired 4/2025 that was opened and used.- lying on a layer of water along the top shelf in the medication fridge were vials of influenza vaccines and refrigerated medication bags. - a box of high dose influenza vaccine, unopened, that expired 6/2025. The Director of Nursing stated the lidocaine hydrochloride 1% vials were resident specific and could not be utilized for multiple residents. They were unsure why they (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were with the house stock of medications, and they should have been disposed of. The did not have a pharmacy label as they were likely pulled from the Omnicell emergency medication supply. They stated they did not use that brand of protective cream anymore and stated they were unaware of why it was in the treatment cart. Treatment carts should be checked monthly to make sure nothing was expired. The facility had not administered the influenza vaccine in months, and they did not know why there was expired vaccines in the fridge.Unattended and Unlocked Medication Cart:During an observation and interview on 7/30/2025 at 1:48 PM, Licensed Practical Nurse #15 left the medication cart open by a resident room unlocked and unattended as they went down the hallway and around the corner to retrieve a ginger ale. Licensed Practical Nurse #15 stated medication carts were to be locked so confused residents did not get into the cart.During a follow up interview on 7/30/2025 at 2:06 PM, Licensed Practical Nurse #15 stated they locked the medication cart when they out of sight of the cart. They should not have left the cart unlocked to go get a ginger ale and not in sight, but they were busy and forgot. The policy for locking the medication cart should be followed to keep people who wander from getting into the medication cart and getting harmed.10NYCRR 415.18(d)

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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. Based on observations, record review, and interviews during the recertification survey conducted 7/29/2025-8/1/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for one (1) of two (2) kitchenette areas. Specifically, the 3rd floor kitchenette contained staff food items that were not properly stored, undated food items in the refrigerator, dishes were not dried properly after washing, and the air conditioning vent had debris on it.Findings include:The facility policy Unit Pantries effective 12/2024 documented dietary would check all unit pantry refrigerators and cupboards daily and discard items that were not labeled, not dated, expired, or items opened not sealed or covered properly. Unit refrigerators in the pantry were for resident items only and staff should not consume or store products in the resident refrigerators.The facility policy Sanitary Conditions effective 12/2024 documented storage areas including cupboards, shelves, and drawers were to be kept dry and clean from debris.During an observation of the 3rd floor kitchenette on 7/31/2025 between 10:38 AM and 11:04 AM:- 1 opened 16-ounce energy drink was in the refrigerator.- 17 individual 2-ounce dressing cups with lids were undated in the refrigerator.- 37 various 4-ounce and 6-ounce juice cups were stacked inside the cupboard and wet. There was a wet spot on the shelf where the cups were stacked.- 27 insulated plate domes and bottoms were stacked and wet.- the air conditioning vent near the steam table had debris on it.During an interview on 7/31/2025 at 11:04 AM, Food Service Worker #19 stated they did not see the cups stacked in the cupboard but there was a wet spot where they were stacked. They did the dishes and did not check to make sure they were dry. The 27 insulated plate domes and bottoms were also stacked wet. During an interview on 7/31/2025 at 11:22 AM, the Food Service Director stated maintenance should have been cleaning the air vents in the kitchenette monthly to prevent the potential for physical contamination of food items while food was being served. It was the responsibility of the server during meals to ensure dishes were dry before bringing them upstairs. If dishes were stacked wet, it could have potentially led to bacterial growth. The refrigerators in the kitchenettes were for the residents. Facility staff should not have put their personal items in the resident refrigerator because they had their own breakroom and if the food item was opened it could have led to cross contamination.During a follow up interview on 8/1/2025 at 4:00 PM, the Food Service Director stated they did not date items on the production sheet. They knew they needed 17 salad dressings, they were prepped that day, and they used a full gallon of ranch dressing each day, but they expected thing to be dated.10NYCRR 415.14(h)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interviews during the recent recertification survey conducted 7/29/2025-8/1/2025 the facility did not ensure the results of the most recent survey and the corresponding plan of correction were readily accessible to residents and their representatives, as required. Findings include:The facility policy Resident Rights, revised in April 2022, documented the residents/family members/responsible party of resident's rights by posting within the facility, information to provide access to any representative or governmental agent as outline in federal and state code, legal or other services. During a Resident Council meeting on 7/30/2025 at 11:26 AM, the residents in attendance were unaware of the location of a copy of the most recent Statement of Deficiencies (Form CMSˆ2567) or Plan of Correction.During an observation on 7/30/2025, the main lobby had no visible information indicating the detailed availability of past survey information. Upon inspection, the survey binder was discovered in the lobby on top of a shelf, under a plant with random unrelated papers placed on top. The folder contained the results of complaint surveys from 2024.During an interview on 8/1/2025, front desk Receptionist #5 stated they did know the location of the folder that contained the state survey results. They were not aware the results were required to have been readily accessible to all residents and families. During an interview on 8/1/2025 at 4:25 PM, the Administrator stated they were responsible for the placement of the survey results. The binder should have been placed where the residents could have accessed them. 10 NYCRR S 415.3(c)(1)(v)