STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335541	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Care Community of New York	2150 Bleecker Street Utica, NY 13501

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48052 Based on observation, record review, and interview during the recertification survey conducted 5/13/2024 -5/17/2024, the facility did not ensure a resident's ability to safely self-administer medications was clinically appropriate for 2 of 6 residents (Residents #96 and #155) reviewed. Specifically, Resident #96 was observed with prescribed eye drops and nasal sprays at their bedside and there was no documented evidence the resident had an assessment or order to self-administer the medications. Additionally, Resident #155 was observed with prescribed eye drops at their bedside and did not have an assessment or order to self-administer the medications. Findings include: The facility policy Self-Administration of Medication Program reviewed 11/2016 documented the interdisciplinary team would determine if a resident was clinically appropriate for self-administration of medications, and reviewed on a quarterly and significant change basis. That decision would be documented in the resident's record. A physician order was needed prior to initiation of the program specifying the specific medications the resident would be self-administering. Resident education would be done. The unit nurse would monitor at all times if the medications were taken and document accordingly. 1) Resident #96 had diagnoses including Parkinson's disease, bipolar disorder, and chronic obstructive pulmonary disease. The 12/28/2023 Minimum Data Set assessment documented the resident understood and was able to make self-understood, wore corrective lenses, had full cognition, choice was important, used a walker or wheelchair, and was set-up only for eating. The 11/10/2023 through 5/3/2024 vision consults documented the resident was seen for previous cataract surgeries. Eye drops were ordered. There was no documentation the resident was able to self-administer the eye drops. The 1/23/2024, 3/13/2024 and 4/1/2024 30/60 day physician progress notes by the Medical Director did not document the resident had the ability to self-administer medications. The 3/23/2024 physician orders by Nurse Practitioner #16 documented: - Fluticasone propionate (steroid medication) 50 micrograms per actuation nasal spray, instill 1 spray by nasal route daily in each nostril for allergic rhinitis; and, (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cough drops 2.7 milligrams give 1 by mucous membrane as needed and may leave at bedside to be used as needed. There was no order to leave fluticasone propionate at the bedside for self-administration. The 3/23/2024 comprehensive care plan documented the resident was non-compliant, had Parkinson's Disease, had impaired vision, had cataract removal, had bipolar disease, refused medications at times, could self-administer polyethylene glycol 3350 (brand name, Miralax, a laxative) and would self-administer nebulizer treatments safely. Interventions included provide supervision as appropriate, eyeglasses, give medications as prescribed, may keep post-operative eye drops at bedside and self-administer per instructions, educate on importance of medication consistencies, encourage to take medications, report concerns to medical provider, prepare laxative per order for self-administration, set up nebulizer machine for resident to self-administer nebulizer treatment, and follow up 30 minutes post self-administration to ensure all medication administered. The care plan did not document the resident could self-administer nasal spray or eye drops. The 3/27/2024 Nurse Practitioner #16 readmission after elective surgery note did not document the resident was able to self-administer medications. The 5/3/2024 physician orders by the Medical Director documented: - FML Liquifilm 0.1% eye drops instill one drop in each eye 2 times per day for macular degeneration (loss in the center of field of vision). - Muro 128 5% eye ointment instill in each eye once daily at bedtime to lower lid for macular degeneration. - Refresh celluvisc 1% eye gel in dropperette instill one drop in each eye once daily for dry eye syndrome; and, - Zaditor 0.025% (0.035%) eye drops instill 1 drop in each eye 2 times per day for macular degeneration. There was no order to leave at bedside for self-administration. The April 2024 and May 2024 Medication Administration Records documented the eye drops were administered as ordered. On 5/13/2024 at 12:04 PM, Resident #96 was observed in their room with eye drops on the bedside table. On 5/15/2024 at 8:48 AM, the resident was observed sitting in their recliner with multiple prescription nasal sprays and eye drops on the bedside table. The resident stated they self-administered the eye drops and nasal sprays. During a follow-up observation at 10:41 AM, the resident was not in their room. The eye drops and nasal sprays remained on the bedside table next to the recliner. On 5/16/2024 at 9:25 AM, the resident was again observed to have eye drops and nasal sprays left on the bedside table. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/16/2024 at 10:20 AM, Licensed Practical Nurse #14 stated they were not sure if the resident was allowed to self-administer medications, was not sure if there was a physician order, and had informed the nurse manager they needed one. The nurse would ask the resident if they took the eye drops and nasal sprays, and then would sign in the Medication Administration Record as given. During a follow-up interview at 2:48 PM, Licensed Practical Nurse #14 stated they asked the resident why the eye drops and nasal sprays were in the room. The resident had then thrown them in the garbage. They should have removed the medications from the room instead of letting the resident throw them away. The resident would not give the medications to the nurse. The resident had a lot of home medications delivered to them and staff had to check to ensure the resident did not have any in the room. When interviewed on 5/16/2024 at 3:16 PM, Registered Nurse Manager #15 stated any resident wishing to self-administer medications needed a physician order specifically for that medication. An assessment was done for competency. Resident #96 had a post-operation order to self-administer the eye drops that was discontinued. The manager did not know why the nurses were leaving the nasal sprays and eye drops in the room and did not know the resident preferred to self-administer them. 2) Resident #155 had diagnoses including dementia and glaucoma. The 4/20/2024 Minimum Data Set assessment documented the resident had difficulty seeing, wore corrective lenses, had moderately impaired cognition, and required moderate to maximum assistance with most activities of daily living. The 4/5/2024 physician orders by the Medical Director documented: - Lumigan 0.01% eye drops instill 1 drop in each eye at bedtime for high ocular pressure and please wait 5 -10 minutes between administering other eye drops. - Rhopressa 0.02% eye drops instill 1 drop in each eye at bedtime for high ocular pressure and please wait 5 - 10 minutes between administering other eye drops. - Timolol Maleate 0.5% eye drops instill 1 drop in each eye twice a day for high ocular pressure and please wait 5 - 10 minutes between administering other eye drops. - Patanol 0.1% eye drops instill 1 drop in each eye twice a day for high ocular pressure and please wait 5 -10 minutes between administering other eye drops. - Pilocarpine 1% eye drops instill 1 drop in each eye four times a day for high ocular pressure and please wait 5 - 10 minutes between administering other eye drops; and, - Nurse to administer all eye drops. Please do not leave eye drops at bedside. The 4/5/2024 comprehensive care plan documented the resident had impaired vision and had glaucoma. Interventions included report visual changes, wore corrective glasses, refer to eye specialist if needed, administer eye medication per orders, and could keep eye drops at bedside with nursing to observe resident taking them as prescribed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/1/2024 30/60 day physician progress note by the Medical Director documented the resident was upset they were not allowed to self-administer eye drops. The Medical Director had explained the difficulty of administering the eye drops appropriately. The resident's cognition was getting worse. The resident was not accepting the reality of their decline. The plan was for nursing to continue administering the eye drops. The 4/8/2024 30/60 day physician progress note by the Medical Director documented the resident had short-term memory deficits, denied vision changes, and was on multiple eye drops. The note did not document the resident could self-administer eye drops. The April 2024 and May 2024 Medication Administration Records documented all eye drops were administered as ordered. The 5/5/2024 at 7:31 AM interdisciplinary progress note by Licensed Practical Nurse #23 documented the resident had eye drops in their nightstand drawer and was not allowed to have them there or self-administer them. They tried to remove them from the drawer on evening and night shifts and were unsuccessful due to the resident's refusal. The nurse did administer the eye drops. When interviewed on 5/15/2024 at 10:52 AM, Resident #155 stated they used to have their eye drops in the room. The nurse took them out and now they did not know their scheduled administration times. When interviewed on 5/16/2024 at 10:20 AM, Licensed Practical Nurse #14 stated the resident was not allowed to have medications in their room. The resident was allowed to have the eye drops in the room in the past but was getting more confused. They were not allowed to keep medicatons in their room starting about 2 - 3 months ago. They were not sure how the resident got the eye drops in their room but the resident would not give them back to nursing. They administered the eye drops to the resident and sometimes left them in the room. Sometimes they let the resident self-administer the eye drops when they were agitated, but only under supervision. They knew they were not supposed to do that as there was no order for self-adminstration of the eye drops. When interviewed on 5/16/2024 at 3:16 PM, Registered Nurse Manager #15 stated any resident wishing to self-administer medications needed a physician order specifically for that medication. An assessment was done for competency. Currently, Resident #155 did not have an order to self-administer eye drops. The unit nurse should not leave them bedside without an order to do so. The care plan should not contain reference to self-administer the eye drops if the resident did not have a current order to do so. When interviewed on 5/17/2024 at 8:32 AM, Nurse Practitioner #16 stated they could assess the resident and determine if they were capable to self-administer medications. An order was then entered into the electronic medical record allowing the self-administration of that particular medication. When interviewed on 5/17/2024 at 9:02 AM, Assistant Director of Nursing #2 stated care plans should be accurate and up-to-date. Care plans were reviewed quarterly and with significant changes. Resident #155's care plan should have been updated as it was confusing as to whether the resident was able to self-administer the eye drops or not. No medications should be left at bedside unless the resident had a self-administration order for that specific medication, as another resident could enter the room and take the medication not prescribed them. There was also no way of knowing if the resident was taking the medication as ordered. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10NYCRR 415.3(e)(1)(vi)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48052 Based on record review and interviews during the recertification survey conducted 5/13/2024 -5/17/2024, the facility did not ensure they had a process in place for residents to have their grievances addressed appropriately for 6 of 8 anonymous residents. Specifically, 6 anonymous residents present at the Resident Council meeting stated they did not know how to file a grievance. Additionally, the facility did not have a process for residents to file a grievance anonymously. Findings include: The facility policy Resident Grievances, dated 11/2016, documented every resident of the facility and/or their resident representative had the right to voice grievances to the facility without fear of reprisal or discrimination. Grievances included those with respect to care and treatment which had been provided as well as those which had not been provided, the behavior of staff and of other residents, and other concerns regarding their stay at the facility. The facility would make prompt efforts to resolve a grievance. All complaints and/or grievances presented by a resident and/or the resident representative would be forwarded to the Director of Social Services as the designated Grievance Official and documented on the Resident Grievance Form. The form would be completed by the staff involved in the grievance which included the resolution. The facility policy did not state how residents were informed of their right to file a grievance or how to do so anonymously. The grievance log for year 2024 documented one grievance in total for the facility. On 5/14/2024 at 10:44 AM the grievance policy was observed in the front lobby inside a locking glass wall case in the upper right top corner which was above head height when standing. During a Resident Council Meeting on 5/13/2024 at 3:33 PM, 6 anonymous residents stated they did not know how to file a grievance. They had verbalized concerns to the social workers in the facility regarding whether their unit had a process to file a grievance. 2 anonymous residents stated they did not hear back about a resolution to their concerns or questions. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/2024 at 10:39 AM, the Social Services Director stated they did not have too many formal complaints in the facility. Formal complaints were considered grievances, so many concerns did not always come directly to them. Grievances or concerns were a team approach. If a grievance was received, the Administrator reviewed the grievance which then got distributed to the appropriate parties. The social services department was responsible for interviewing alert and oriented residents residing on the households. They were unaware of how residents were educated on the grievance process. If there was a concern, they informed the resident and/or resident's family the process of a grievance investigation. Nursing was responsible for any action in regards to concerns with the nursing staff, and did not always know the outcome. A concern did not always rise to the level of a grievance; it would still be investigated but not documented on a formal grievance form. If a resident wanted to file an anonymous grievance, they could call the Department of Health. Any staff member could provide that number to a resident. They were not aware of any internal process to file an anonymous grievance. During an interview on 5/17/2024 at 9:27 AM, Licensed Practical Nurse #13 stated they were unsure of the process for residents to file a grievance but knew there was a form that would be filled out. They thought residents had to speak with the Ombudsman as part of the process of filing a grievance. During an interview on 5/17/2024 at 9:30 AM, Certified Nurse Aide #12 stated they were unsure of how a resident filed a grievance. They thought residents would have to speak to the nurse manager or the social worker. During an interview on 5/17/2024 at 9:32 AM, the Administrator stated they had two different processes for addressing resident grievances in the facility. The first process was for formal written grievances, which were addressed with a letter provided to the complainant stating the outcome. The second process was for family and resident concerns, such as a family member wanting a resident to attend more activities, which did not rise to the level of a grievance. They had never had a resident file an anonymous grievance. If a resident had an anonymous grievance they wanted to file, they were encouraged, during resident council meetings, to call the Ombudsman. They would have to check with the admissions department to see if the right to file grievances was addressed in the admission packet. If it was not addressed in the admission packet, they would have to check with the social workers to see if it was reviewed during the admission meeting. 10NYCRR 415.3(C)(1)(ii)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48052 Based on record review and interview during the recertification survey conducted 5/13/2024 - 5/17/2024, the facility did not ensure a comprehensive, person-centered care plan was developed and implemented to meet a resident's medical and nursing needs for 1 of 5 residents (Resident #170) reviewed. Specifically, Resident #170 did not have a comprehensive, person-centered care plan that included anticoagulant (blood thinner) therapy. Findings include: The facility policy Interdisciplinary Comprehensive Care Plans (IDCP), reviewed 2/2022, documented a person-centered interdisciplinary care plan would be developed by the Interdisciplinary Care Team to identify a resident's problems, strengths and needs, and incorporate their personal and cultural preferences. The interdisciplinary care plan would be used to ensure services were provided to assist the resident achieve or maintain their highest practicable physical, mental, and psychosocial well-being. Resident #170 had diagnoses that included long-term use of anticoagulants, personal history of other venous thrombosis (blood clot) and embolism (block in blood flow due to clot), and personal history of pulmonary embolism (blocked lung artery). The 2/28/2024 Minimum Data Set assessment documented the resident was cognitively intact, was on an anticoagulant with an indication noted, and was supervision to independent for most activities of daily living. The comprehensive care plan, dated 11/21/2022, documented the resident was at low risk for falls. The interventions included to monitor the environment for fall hazards, to encourage non-skid socks and to assist to the bathroom at 4:00 AM daily. The comprehensive care plan did not include the resident received anticoagulant medication or any interventions related to the anticoagulant medication use. Physician orders dated 2/1/2022 and renewed 4/16/2024 documented the resident took one apixaban (brand name Eliquis, a blood thinner) 2.5 milligram tablet by mouth two times per day related to a personal history of other venous thrombosis and embolism. During an interview on 5/16/2024 at 12:29 PM, Certified Nurse Aide #12 stated they knew how to care for a resident based on their plan of care, which was located in a resident's electronic health record. There was also a copy of the care plan posted in a resident's closet. Residents on anticoagulant medication needed to be monitored for bruising. The nurse manager was responsible for the plans of care which were then distributed to the staff so they knew how to care for a resident. During an interview on 5/16/2024 at 12:39 PM, Licensed Practical Nurse #13 stated staff knew how to care for a resident based on their care plan, which was located in the certified nurse aide book and in each resident room in a resident's closet. If a resident was on anticoagulant medication, they were to monitor with routine labs and monitor for bruising. They were unsure if anticoagulant interventions were on Resident #170's plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 5/16/2024 at 3:16 PM, Nurse Manager #15 stated they were responsible for ensuring the development of and the updating of comprehensive care plans with input from other departments in the facility. The care plan was a snapshot of the specific care needs of a resident. Care plans were reviewed annually to verify if the interventions were still appropriate. If a resident was on anticoagulant therapy, it would be a part of the care plan. There was a specific template for an anticoagulant therapy care plan in the electronic medical record that they utilized. Nurse Manager #15 then reviewed Resident #170's plan of care and stated the template for anticoagulant therapy had not been initiated, which meant there was no care plan related to anticoagulant therapy. Resident #170 should have had a care plan for anticoagulant therapy. During an interview on 5/17/2024 at 9:02 AM, Assistant Director of Nursing #2 stated the purpose of a resident's care plan was to inform the staff of what they needed to know about a resident and how to care for that resident. If a resident was on anticoagulant therapy, they should have had a care plan that addressed it. Care plans were updated quarterly and as needed, and should always be accurate and up-to-date. If a care plan was not up-to-date or accurate, the resident could be provided the wrong care. 10NYCRR 415.11(c)(1) 48632 49831

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48052 Based on observation, record review, and interview during the recertification survey conducted 5/13/2024-5/17/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 4 residents (Resident #106) reviewed. Specifically, Resident #106 was ordered to have bilateral heel float boots on 4/29/2024 and did not receive the left boot until 5/12/2024. The undated facility policy Skin Assessment for Admissions or Change of Condition: Skin Prevention Protocol documented there were three categories for a resident's skin that required physician orders and care plan interventions: high risk, moderate risk, and a skin tear. High risk included orders for a pressure guard mattress, specialty cushion, heel float boots (brand name Skil-Care) to bilateral feet when in bed, skin prep to heels, and an occupational therapy referral to recommend positioning aides. Interventions geared towards skin and skin protocol would be documented on the care plan. Moderate risk orders included a standard gel wheelchair cushion, physical and occupational evaluation for moderate skin risk, barrier cream and lotion to skin. The undated facility policy Resident Care Guide: AOD Point of Care documented the resident care guide would be reviewed by the assigned caregiver prior to delivery of care to a resident. Staff would provide care in accordance with the resident care guide located on the kiosk and in the resident's room. Any care that was not given would be reported to the nurse and the reason documented in the resident's chart. The resident's care guide would include resident-specific skin care interventions, which included pressure relieving devices. Resident #106 diagnoses included peripheral vascular disease (a circulation disorder), diabetes mellitus type 2 with diabetic neuropathy, and heart failure. The 4/17/2024 Minimum Data Set assessment documented the resident was cognitively intact, was dependent for toileting, lower body dressing, putting on/taking off footwear, and transfers, had one or more pressure ulcers: one was unstageable, and one was an unstageable deep tissue injury, was at risk for developing pressure ulcers, and had two venous and arterial ulcers. The resident had a pressure-reducing device for the wheelchair and the bed, nutrition/hydration intervention, pressure ulcer/injury care, application of non-surgical dressings, applications of medications/ointments, and application of dressings to feet. The comprehensive care plan initiated 3/18/2024 documented the resident was at high risk for skin breakdown related to decreased mobility, obesity, and comorbidities. Interventions included heel protection by having heels propped up by pillows and heel float boots to left and right foot on at all times except for hygiene. The care plan also documented the resident's basic care needs and preferences for daily routine would be honored. Interventions included a pressure-relieving cushion in their chair for comfort and positioning and was dependent on one assist for footwear. The 4/29/2024 wound care follow-up consult note documented the left heel deep tissue injury was stable in size and appeared to be resolving. There was no sign of on-going pressure injury. The recommendation for the left heel was for skin prep and bilateral heel float boots (brand name Skil-Care) while in bed. Further instructions documented heel cup for protection and support bandage (brand name Tubigrip) daily to the left heel. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/29/2024 physician's order by Nurse Practitioner #19 documented the resident was to have bilateral lower extremity heel float boots (brand name Skil-Care) on at all times except for during the skin checks on every shift. The May 2024 Medication Administration Record nursing comments documented the following for the resident's order for bilateral heel float boots: - On 5/1/2024 on the 11:00 PM to 7:00 AM shift by Licensed Practical Nurse #21: The resident had only the right one on and the left one was not found. - On 5/6/2024 on the 11:00 PM to 7:00 AM shift by Licensed Practical Nurse #21: The resident had only the right one on and the left one was not found - On the 5/10/24 on the 11:00 PM to 7:00 AM shift by Licensed Practical Nurse #22: The resident only had the right one on. The resident stated they had never had a second one. The supervisor was notified. A 5/11/2024 at 7:16 AM interdisciplinary progress note by Registered Nurse Supervisor #20 documented the resident had an order for bilateral heel float boots but only had one boot for the lower right extremity. They were unable to locate another heel float boot in the nursing emergency storage closet. During an observation and interview on 5/13/2024 at 12:33 PM, Resident #106 was observed wearing bilateral blue, soft heel float boots. They stated they had gone to a wound clinic appointment a few weeks ago (4/29/2024) for their foot wound. It took the facility two weeks to get the heel float boot for their left foot that was recommended by the wound care clinic. They had received the second boot this past weekend (5/12/2024). A 5/14/2024 at 4:26 PM interdisciplinary progress note by Registered Nurse Unit Manager #15 documented that during the resident's skin check it was noted the resident's left heel had a 0.1 centimeter x 0.1 centimeter yellow, sloughing (dead/dying tissue) dry scab, the left great toe had a small, yellow fluid-filled blister, and there was fresh blood draining from the skin between the toes. A new order for a protecting cream (brand name Eucerin) was obtained. During an interview on 5/16/2024 at 2:53 PM, Licensed Practical Nurse #14 stated the resident received their heel float boot for the right foot right away but did not receive their left heel float boot until a couple of days ago. They were unsure why the resident had not received the left heel float boot sooner. They and the other nurses had marked the resident had bilateral heel float boots in place in the medication administration record when they should not have, as the resident had only had one heel float boot. They should have charted the resident only had the right heel float boot. The resident told them they had been asked by a couple of managers why they only had one heel float boot, but no one had provided the second heel float boot. The nurse managers usually provided the heel float boots to the nursing staff for the residents who had them ordered. They were aware the heel float boots were kept in the nursing storage room on the second floor but had not gone to get a second heel float boot for the resident. (continued on next page)

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	335541	A. Building B. Wing	05/17/2024

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Masonic Care Community of New York	2150 Bleecker Street Utica, NY 13501

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2024 at 3:16 PM, Registered Nurse Unit Manager #15 stated the heel float boots were in the clean utility room and in the laundry room. If there were no heel float boots available, the unit secretary would order more from central supply, and they would be delivered to the unit the same day. Resident #106 needed two heel float boots as that was the order they had entered. They did not always go and retrieve the heel float boots when they entered the order as they expected the floor nurses to obtain them for the resident. They received an electronic message on 5/11/2024 from the floor nurse that stated the resident had still not received the left heel float boot from when the order was entered on 4/29/2024. They retrieved a heel float boot on 5/12/2024 from the second floor storage room as the supervisor on duty on 5/11/2024 was unable to locate one. The nurses should not have been signing off that the resident had both heel float boots when the resident only had the right heel float boot. They should had documented the resident only had the right heel float boot and then gone and retrieved a left heel float boot. The resident had bad skin and was highly susceptible to new skin issues and breakdown. The resident was on their radar for skin issues and went to the wound clinic regularly. During an interview on 5/17/2024 at 8:32 AM, Nurse Practitioner #16 stated it was an issue if a resident had an order entered on 4/29/2024 for bilateral heel float boots but did not receive the left heel float boot until 5/12/2024. They expected to be notified if there was a delay in obtaining the heel float boots. They performed medical rounds once weekly so there was opportunity for it to be discussed with nursing. Resident #106 was at risk for skin breakdown without wearing the second heel float boot that was ordered. Medical orders needed to be followed. If there was a reason why they could not be followed, a medical provider needed to be notified. During an interview on 5/17/2024 at 9:02 AM, Assistant Director of Nursing #2 stated it was an issue if an order for bilateral heel float boots was entered on 4/29/2024 but the resident did not receive one of the heel float boots until 5/12/2024. The resident could potentially have skin breakdown or the wound worsening on the heel that did not have the heel float boot. If a heel float boot was not available, the nursing staff should have notified the nurse manager, or the nurse supervisor during an off-shift, so they could get the ordered heel float boot. 10NYCRR 415.12(c)(1)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 44838 Based on observation, record review, and interview during the recertification survey conducted 5/13/2024 -5/17/2024, the facility did not ensure residents were assessed for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative, or obtain informed consent prior to the installation of bed rails for 1 of 1 residents (Resident #40) reviewed. Specifically, for Resident #40, there was no documented evidence of a bed rail assessment prior to bed rail installation, that the risks and benefits of bed rails were explained to the resident or their representative, or that consent was obtained prior to bed rail installation. Findings include: The undated facility policy Bed Rail Policy documented the facility would utilize approaches to identify and reduce safety risks and hazards commonly associated with bed rail use, including individual bed rail evaluations. Residents would be screened upon admission, readmission or change of condition. Prior to the installation of bed rails the following would be done: - The resident would be assessed for risk of entrapment from bed rails. Bed rails would not be used when a resident could not raise and lower them easily and would not be used for staff convenience or discipline. - If the Interdisciplinary Team had determined that bed rails were safe and appropriate for use, the risks and benefits of bed rail use would be reviewed with the resident and/or resident representative, and informed consent would be obtained and documented. - A physician order would be obtained for bed rail use, including the medical symptom contributing to the need. - Use of the bed rail would be indicated on the care plan. 1) Resident #40 had diagnoses including polyneuropathy (nerve damage impacting sensation and coordination), vascular dementia, and morbid obesity. The 4/25/2024 Minimum Data Set assessment documented the resident was cognitively intact, had functional limitation with range of motion with impairment of one arm, was dependent for rolling side to side, sit to lying, lying to sitting on edge of the bed, and transfers, and did not use bed rails. The 11/1/2021 admission bed rail assessment documented the rationale for potential use of bed rails and included the resident was non-ambulatory due to a left above-the-knee amputation and a right below-the-knee amputation. Assist rails on both sides of the upper bed were recommended to increase the resident's independence. There was no current, documented bed rail assessment for the use of half bed rails and no informed consent for use of half bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/13/2024 comprehensive care plan documented the resident was dependent of two-person hands-on assistance with rolling from left to right. Staff could use a slide sheet for repositioning. There was no documentation in the care plan for bed rail use. There were no physician orders for the use of bed rails. Resident #40 was observed: - On 5/13/2024 at 10:58 AM, in bed with half bed rails up on both sides of the bed. - On 5/14/2024 at 8:52 AM, in bed with half bed rails up on both sides of the bed. - On 5/15/2024 at 11:04 AM, in bed with both half bed rails up on both sides of the bed. When interviewed, the resident stated they did not use the bed rails very often and they were used to keep them from falling out of bed. During an interview on 5/15/2024 at 9:45 AM, Certified Nurse Aide #5 stated Resident #40 had bed rails to pull themselves up in bed and to keep them from falling out of bed. They believed bed rails were documented in the care plan and there was an order for them. Bed rails could be dangerous. If the resident got stuck they could break a bone. During an interview on 5/15/2024 at 9:53 AM, Registered Nurse Unit Manager #3 stated bed rails were utilized for repositioning, enhanced mobility, and independence. Physical therapy completed and documented the assessment for bed rails, and then maintenance installed them. Bed rails were documented in the care plan and did not require a physician order. They required consent by either the resident or their representative after risks and benefits were discussed with the resident as bed rails could cause entrapment, strangulation, skin tears, broken bones, or bruising. An admission assessment had been completed on 11/1/2021 for assist rails, and they were not sure if a periodic reassessment was required by nursing or physical therapy. The facility used two types of bed rails: assist rails and half bed rails. Resident #40 had half bed rails for positioning and had a bed rail assessment completed for assist rails. The manager stated that half bed rails carried a bigger risk for injury than assist rails. During an interview on 5/15/2024 at 10:27 AM Assistant Director of Nursing #2 stated bed rails were used to increase bed mobility and independence after being assessed by physical therapy. Physical therapy assessed the ability of a resident to use the bed rails safely and the bed rails had to increase a resident's function. The risks and benefits were reviewed with a resident or their representative and a consent form was to be signed prior to usage. Bed rails could cause injuries such as skin tears and entrapment. Bed rails were documented on a resident's care plan and were reassessed quarterly, on readmission, and with any change in condition for continued ability and necessity. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 10:50 AM Director of Physical Therapy #4 stated each resident was screened on admission to determine if bed rails were appropriate for turning and positioning. If it was determined bed rails were appropriate, they would notify the nurse manager. They reviewed with the resident or their representative the risks of the bed rails which included injuries or entrapment. If bed rails were appropriate, they would be added to the care plan by nursing. There was a specific form in the electronic health record that they filled out for the bed rail assessment. Residents were reassessed quarterly or with change of condition to make sure bed rail use was still appropriate. The risk/benefit and consent was required by regulation and half bed rails carried a greater risk than a hand assist rail due to size. 10NYCRR 415.12(h)(1)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44838 Based on record review and interviews during the recertification survey conducted 5/13/2024 - 5/17/2024 the facility did not ensure that residents were free of any significant medication errors for 1 of 1 residents (Resident #28) reviewed. Specifically, Resident #28 did not receive four consecutive doses of carbidopa - levodopa (brand name Rytary, used to treat Parkinson's Disease) on 5/11/2024 -5/12/2024 as physician ordered. Findings include: The 5/2024 revised Medication Administration policy documented if medication was not available at the time it was to be administered, the nurse was to notify the Nurse Manager/Supervisor. The Nurse Manager/Supervisor would explore alternative methods for obtaining medication such as the backup medication storage (Omnicell), contacting the pharmacy or contacting medical for an alternate medication. Resident #28 was admitted to the facility with diagnoses including Parkinson's Disease. The 4/10/2024 Minimum Data Set assessment documented the resident was cognitively intact, used a walker and wheelchair for mobility, and required partial to moderate assistance with upper and lower body dressing, personal hygiene, and ambulation. A 4/25/2024 physician order documented carbidopa - levodopa 23.75 milligrams - 95 milligrams capsule extended release; give two capsules by mouth three times daily at 8:00 AM, 1:00 PM and 6:00 PM. The May 2024 Medication Administration Record documented carbidopa - levodopa 23.75 milligrams - 95 milligrams was not administered due to being unavailable on: - 5/11/2024 at 6:00 PM. - 5/12/2024 at 8:00 AM. - 5/12/2024 at 1:00 PM. - 5/12/2024 at 6:00 PM. Interdisciplinary progress notes documented: - On 5/11/2024 at 10:23 PM by Licensed Practical Nurse #9: Carbidopa - levodopa 23.75 milligrams - 95 milligrams capsule extended release was out. Pharmacy called, awaiting delivery, supervisor aware. - On 5/11/2024 at 10:37 PM by Registered Nurse Supervisor #10: Resident missing last dose of carbidopa - levodopa 23.75 milligrams - 95 milligrams that evening. Pharmacy notified. Medication not provided on last run of pharmacy. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/12/2024 at 1:52 PM by Registered Nurse Supervisor #11: Call placed to pharmacy because resident had still not received their carbidopa -levodopa 23.75 milligrams - 95 milligrams. Per pharmacy a new prescription was sent out and the medication would arrive on the next pharmacy run. There was no progress note by nursing documenting that medical was notified of the missed doses of carbidopa -levodopa 23.75 milligrams - 95 milligrams. During an interview on 5/14/2024, Licensed Practical Nurse #18 stated medications were reordered by the nurses as needed. Residents should not run out of medication; sometimes if a pill was dropped or wasted, they may run out of medicaton. If a medication was not available, pharmacy needed to be called. They would check and see if it was available in the backup medication storage (Omnicell), then notify the supervisor. The supervisor was supposed to communicate with medical for instructions. Parkinson's Disease medications were supposed to be given to prevent worsening of tremors, rigidity, and difficulty moving. During an interview on 5/14/2024 at 2:05 PM, Registered Nurse Unit Manager #3 stated medications were reordered by the nurses when they noticed them getting low. The medications came in 30-days at a time and pharmacy was supposed to automatically refill. If a nurse noticed a medication was low, they should reorder right on the Medication Administration Record. If a medication was unavailable, they needed to call the pharmacy to get the medication there as soon as possible. The medication carbidopa -levodopa 23.75 milligrams - 95 milligrams for Resident #28 was not available in the backup medication storage. If a resident was going to miss a dose, medical should have been notified. If that medication was missed for a dose or more than one dose, it could potentially worsen symptoms such as tremors or movement difficulty. Pharmacy sometimes made emergency medication runs. Medical should have been notified of Resident # 28 not receiving their carbidopa -levodopa 23.75 milligrams - 95 milligrams. Physician # 17 was on call, and they were not sure if they were notified. During an interview on 5/14/2024 at 2:40 PM, Physician #17 stated they were on call the weekend of 5/11/2024 - 5/12/2024. If a resident missed a medication, they should have been notified. They were not notified of Resident #28 missing doses of their Parkinson's Disease medication. Missing four doses consecutively of a medication for Parkinson's' Disease could have caused difficulty swallowing, movement difficulty, or increased tremors. It could have negatively affected the resident's quality of care and life. During an interview on 5/14/2024 at 2:47 PM, Registered Nurse Supervisor #11 stated they were the weekend supervisor 5/11/2024 - 5/12/2024. If a resident was missing medications, they would have checked the backup medication storage, then called pharmacy. Medical should be notified of any medications missed. They were notified the morning of 5/12/2024 that Resident #28 missed their medication for Parkinson's Disease for two doses. They called pharmacy and were notified that the dosage had changed, pharmacy fixed the error, and it would be delivered the evening of 5/12/2024. They did not notify medical. Medical should have been notified of the missed doses as they may had wanted to change orders or give further instructions. They were not aware of the effects the carbidopa - levodopa 23.75 milligrams - 95 milligrams was supposed to have on the resident. They believed it was facility policy to notify medical of missed medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/2024 at 9:18 AM, Licensed Practical Nurse #9 stated all nurses were responsible for making sure medications were available. Resident #28 had enough carbidopa -levodopa 23.75 milligrams - 95 milligrams for 2 doses on 5/11/2024. They notified the nursing supervisor and wrote a note. On 5/12/2024 at 6:00 PM there was still no carbidopa -levodopa 23.75 milligrams - 95 milligrams for Resident #28. There was a progress note that a supervisor had called pharmacy, but no physician recommendations were documented. The medication was for Parkinson's' Disease and helped decrease Resident #28's tremors. If they did not receive the medication as ordered, their tremors could worsen. Medical should have been notified of the missed medication. The 5/12/2024 6:00 PM dose was not given. The evening supervisor was aware and stated they would administer a one-time dose when it came in. There was no dose documented as being given on 5/12/2024 evening shift. 10 NYCRR 415.12(m)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 33421 Based on observation and interview during the recertification surveys conducted 5/13/2024-5/17/2024 the facility did not ensure an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment was established and maintained to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #15) reviewed. Specifically, Resident #15 had a urinary catheter bag resting on the floor without a barrier for multiple days of survey. Findings include: The undated facility policy Catheter Care - Nurses Aides Role documented the external catheter tube needed to be kept as clean as possible. The drainage bag should never touch the floor. Resident #15 had diagnoses including urinary retention and a history of urinary tract infections. The 4/27/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent with toilet hygiene, was dependent with transfers, and had an indwelling urinary catheter (a tube inserted into the bladder to collect urine). The 11/8/2023 updated comprehensive care plan documented the resident had a suprapubic urinary catheter (a type of urinary catheter surgically inserted through the skin to the bladder), needed assistance with daily care, was non-ambulatory, and was on long-term antibiotics for urinary tract infection prevention. Interventions included keep the drainage system below bladder level, monitor for symptoms of urinary tract infection, maintain cleanliness and dressing around catheter site, two staff assist with mechanical lift transfers, ensure the drainage bag was emptied at the end of every shift, and provide toileting assistance after meals and as needed. Resident #15 had the following physician orders: - 8/1/22: change catheter drainage bag every 2 weeks and as needed, and catheter care every shift and as needed. - 3/23/23: 16-French (size) with 10 milliliter balloon suprapubic catheter. - 4/26/23: enhanced barrier precautions due to indwelling urinary catheter. - 12/17/23: cleanse suprapubic catheter site with normal saline, apply antibiotic ointment and cover with a 2 x 2 gauze and border dressing; and, - 3/7/24: registered nurse only to change the suprapubic catheter every 6 weeks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 5/13/24 at 11:03 AM, Resident #15 stated the suprapubic catheter caused a burning feeling around the site. The site was covered with a dry 4 x 4 gauze dressing. There were mucous shreds observed in the catheter tubing. The drainage bag was hanging from the door side of the recliner the resident was sitting in, the bag was uncovered, and the bottom of the drainage bag was resting on the bare floor. During follow-up observations at 11:54 AM and 1:30 PM, the resident continued sitting in the recliner and the bottom of the drainage bag remained on the bare floor. On 5/14/24 at 9:02 AM and 1:52 PM, Resident #15 was sitting in a recliner in their room. The catheter drainage bag was hanging from the door side of the recliner and the bottom of the bag was resting on the bare floor. There was no barrier between the catheter drainage bag and the floor. On 5/15/2024 at 9:31 AM and 1:13 PM, Resident #15 was sitting in a recliner in their room. The catheter drainage bag was hanging from the door side of the recliner and the bottom of the drainage bag was again resting on the floor without a barrier. When interviewed on 5/16/2024 at 10:45 AM, Certified Nurse Aide #6 stated catheter drainage bags were to be covered with a privacy bag for dignity, below bladder level, and should not touch the floor at any time to prevent infection. The drainage bags had a port on the bottom that staff cleansed with alcohol wipes to prevent infection prior to and after emptying the bag. Staff usually put a plastic container under the drainage bag in the event it leaked and used as a barrier from the floor. Staff hung the bag from the side of the recliner or bed, and the aide did not realize the bag was touching the floor. The aide stated it was an infection risk if the bottom of the bag rested on the bare floor as germs could travel from the port, into the bag, up the tube and into the body. When interviewed on 5/16/2024 at 11:13 AM, Licensed Practical Nurse #7 stated catheter drainage bags were supposed to hang in a privacy bag, not touching the floor, and below bladder level. The privacy bags were to prevent contamination and ensure dignity. The nurse was not sure if the privacy bags were permeable or non-permeable. The catheter tubing was not supposed to touch the floor for infection control purposes. The nurse noticed on 5/16/2024 that the bottom of the bag was resting on the floor, so they put the drainage bag in a privacy bag and set that in a plastic container. The resident had a history of urinary tract infections. Staff received infection control training yearly that included catheter care. If the bottom of the drainage bag was on the floor without a barrier, it was possible that germs from the floor could enter the bag and travel into the body causing an infection. When interviewed on 5/16/2024 at 3:15 PM, the Registered Nurse Infection Preventionist stated they had heard a resident did not have their catheter bag in a privacy bag, which was permeable. Catheter drainage bags were to hang from a non-moveable area, off the floor, and in a privacy bag. Infection control education was done yearly and included catheter care. The drainage bags were not supposed to touch the floor, as they could potentially leak. If they touched the floor, germs could enter from the opening, travel up the tube, and enter the body thereby causing an infection. All unit nursing staff should check drainage bag positioning when performing resident care. 10NYCRR 415.12(d)(1)