STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44838 Based on observation, interview, and record review during the recertification and abbreviated (NY00338896 and NY00310300) surveys conducted 4/22/2024-4/26/2024, the facility did not treat each resident with respect and dignity and did not provide care for each resident in a manner that promoted enhancement of quality of life for 1 of 2 residents (Resident #3) reviewed. Specifically, Resident #3 was asked to use a bed pan rather than being taken to the toilet as requested. Findings include: The facility policy Resident Rights last reviewed 4/8/2024, documented the facility would assure that all Federal and State laws which guaranteed rights of our residents were followed. These rights included a dignified existence, and to be treated with respect, kindness, and dignity. The facility policy Activity of Daily Living- Supporting last reviewed 10/2023, documented appropriate care and services would be provided for residents who were unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: mobility (transfer and ambulation, including walking); and elimination (toileting). Resident #3 had diagnoses of intervertebral disc degeneration (breakdown of the spine), morbid obesity, and polyneuropathy (weakness, numbness, and burning pain in the limbs). The 3/15/2024 Minimum Data Set assessment documented the resident had intact cognition, had no behavioral symptoms, did not reject care, required staff assistance for transfer sit to stand and on/off the toilet, was continent of bowel, and occasionally incontinent of bladder. The comprehensive care plan revised on 3/11/2024, documented an activity of daily living self-care performance deficit related to general deconditioning and diagnosis of spinal stenosis. Interventions included using a stand lift for transfers and substantial assistance with toileting. The resident was continent of bowel and bladder. Interventions included offer toileting with morning and bedtime medications, before and after meals, and as needed. The care plan did not include the use of a bedpan for toileting needs. The resident care card (care instructions) documented to offer toileting with morning and bedtime medications, before and after meals, and as needed. The resident required substantial assist for toileting and hygiene. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 9:09 AM, Resident #3 stated they had been at the facility since March of 2024. They had spinal stenosis and pinched nerve pain in their back. They were very happy with the care they received but had one bad experience about two weeks ago. The resident stated they rang their call bell during the night to use the bathroom. Certified nurse aide #21 responded and was abrupt but got the stand lift and assisted them to the toilet. A couple of hours later the resident needed to go to the bathroom again. They reluctantly rang their call bell and certified nurse aide #21 responded. Certified nurse aide #21 immediately told the resident that they wanted them to use the bed pan and transferring the resident hurt their back. The resident told the certified nurse aide the bed pan caused them spine and low back pain. The resident suggested the certified nurse aide ask the nurse for help, and certified nurse aide #21 responded the nurse was too old to help. The resident gave in and agreed to use the bed pan with the caveat that it was not easy to make sure they hit the bed pan. The resident stated their urine missed the bedpan and their bed got wet. Certified nurse aide #21 huffed and puffed while changing the bed linens and did not provide them with a dry night gown. The resident felt it was the job of the certified nurse aide to provide them the care they requested, and that it was not very dignified to be asked to use the bed pan when they could use the toilet. The resident reported the actions of the certified nurse aide as they did not want to have it happen again. Certified nurse aide #21 was no longer employed at the facility, and the resident felt the facility responded quickly and appropriately to their concerns. A facility investigation completed by Director of Nursing #6 dated 4/11/2024 documented Resident #3 reported that certified nurse aide #21 had cared for the resident the previous night and assisted them with toileting. The certified nurse aide brought the bedpan to the resident after telling the resident the mechanical lift hurt their back. The resident did not like the way they were treated. The facility investigated Resident #3's allegations. An interview with certified nurse aide #21 documented they went into toilet resident #3 the second time on 4/11/2024 and they informed the resident they were the only staff member on the unit, and the resident would have to use the bed pan. They indicated the registered nurse on the unit was too old to assist with a transfer, therefor they could not use the machine to transfer them. Certified nurse aide #21 stated they assisted the resident onto the bed pan and denied any urine leakage. Certified nurse aide #21 stated they had taken the resident on and off the bed pan several times before without incident. Certified nurse aide #21 was no longer employed at the facility and was not able to be reached for interview during survey. During an interview on 4/26/24 at 9:36 AM, certified nurse aide #22 stated how a resident was spoken to was important to their dignity as it was their home, and staff should make sure they provided respect and dignity. Resident care information was in the computer on the Kardex (care card) and included how a resident transferred, continence, all assistance needed. If a resident was able to use the bathroom, staff should honor their request. If it was suggested to use a bed pan, it may make the resident feel unimportant and uncomfortable. Two staff were required for use of mechanical lifts. If the care plan documented transfer out of bed and use the toilet the resident should use the toilet. During an interview on 4/26/24 at 9:52 AM, registered nurse night Supervisor #23 stated the Director of Nursing had asked them about the incident on 4/11/2024. They were not aware of any resident care issues that night, and not been asked to assist with transfers or care for Resident #3. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/26/24 at 11:18 AM, registered nurse Unit Manager #4 stated on 4/11/2024 Resident #3 reported feeling intimidated and reluctant to ring their call bell again after certified nurse aide #21 was obviously unhappy with having to take them to the bathroom earlier in the shift. Two staff were to always be used with mechanical lifts. If a continent resident asked to use the toilet, they should be assisted to the toilet. The bladder would empty better on the toilet. Resident #3 had pain when using the bed pan due to their diagnosis. It was more dignified to use a toilet if they were able to do so. During an interview on 4/26/24 at 11:58 AM, the Director of Nursing stated Resident #3 reported feeling intimidated by certified nurse aide #21, and therefore agreed to use the bed pan on 4/11/2024 even though it caused them pain. If a resident was able to use the toilet, asked to use the toilet, and was continent that was what should be done. The Director of Nursing stated they had interviewed the registered nurse assigned to the resident's unit the night of 4/11/2024. They stated certified nurse aide had not requested any assistance from the registered nurse with transfers or toileting Resident #3. 10 NYCRR 415.5(b)(1,3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48675 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure a resident's ability to safely self-administer medications was clinically appropriate for 1 of 1 resident (Resident #19) reviewed. Specifically, Resident #19 was observed with glucose tablets (medication to increase low blood sugar) at their bedside and there was no documented evidence the interdisciplinary team had assessed the resident's ability to safely self-administer the medication. Findings include: The facility policy Self-Administration of Medication/Treatment reviewed 7/12/2022 documented as part of the resident's overall evaluation, the nursing home staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident. If the team determined that a resident could not safely administer medications, the nursing staff would administer the medications. Staff would identify and give the charge nurse any medications found at the bedside that were not authorized for self-administration, for return to the family or responsible party. Resident #19 had diagnoses including diabetes. The 1/28/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required partial/moderate assistance with most activities of daily living, and received insulin injections daily. The comprehensive care plan initiated 9/1/2019 documented the resident was unable to self-administer their own medications related to physical impairment. Interventions included nursing would administer all medications as ordered by the provider. The April 2024 physician order summary report, for the date range of 4/1/2024-4/25/2024 did not include an order for glucose tablets or instructions for self-administration of any prescribed medications. During an observation and interview on 4/22/2024 at 1:01 PM, Resident #19 was sitting in their room on the edge of their bed. A clear plastic medication bottle labeled glucose tablet was on their nightstand. The resident stated they found the medication in their purse and took them out and placed them on their nightstand in case their blood sugar was low. They would feel dizzy when their blood sugar was low, and the nurses checked their blood sugar before meals and before bed. They stated they were unsure if they could keep the medication in their room, no staff had said anything about them keeping the bottle next to their bed. The clear plastic medication bottle labeled glucose tablets was observed on the nightstand in the resident's room on 4/23/2024 at 2:48 PM, on 4/24/2024 at 9:16 AM, and on 4/25/2024 at 10:09 AM. There was no documented evidence that a medication self-administration assessment was completed for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 12:11 AM, certified nurse aide #12 stated they were responsible for keeping resident rooms clean and tidy. Medications were not allowed to be kept in resident rooms unless they had permission to self-administer and there were no residents on the unit who were allowed to self-administer medications. If they had found medication in a resident's room, they would notify the medication nurse to remove them. They did not notice any medication bottles in Resident #19's room, or they would have notified the nurse. They stated it was dangerous for Resident #19 to have them on their nightstand because any staff member or resident could see them and take them. During an interview on 4/25/2024 at 12:22 PM, licensed practical nurse #13 stated residents could only have medications in their room if they had an order for self-administration. Resident #19 did not have a self-administration order and they did not notice any medications in their room during their medication passes. It was a risk for Resident #19 to have glucose tablets in their room because it could cause their blood sugar to get very high, or another resident could wander in the room and take them. During an interview on 4/25/2026 at 2:30 PM, registered nurse Unit Manager #4 stated residents could have medications in their room if they had a physician order and their care plan said they were safe to self-administer. If staff saw medication in Resident #19's room, they expected them to remove it and notify a nurse or supervisor immediately. Resident #19 did not have an order for glucose tablets. If Resident #19 self-administered the glucose tablets their blood sugar could get very high. They needed to know if the resident was hypoglycemic (low blood sugar) so they could monitor them and adjust their insulin as needed. During an interview on 4/26/2024 at 9:42 AM, the Director of Nursing stated a resident would need an order to self-administer and keep medications in their room. Only a provider could determine if they were safe for self-administration. The provider would write an order and it would also be put in the care plan. Resident #19 was not able to self-administer medications so they should not have glucose tablets at their bedside. Staff should have removed them immediately. It put Resident #19 at risk to have the glucose tablets because they were a brittle diabetic. It was important for the nurses to know Resident #19's actual blood sugars and if they were hypoglycemic or hyperglycemic (high blood sugar) so they could adjust their medications accordingly. 10NYCRR 415.3(e)(1)(vi)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not develop and implement a comprehensive person-centered care plan to meet the resident's medical and nursing needs for 2 of 2 residents (Resident #4 and #32) reviewed. Specifically, Resident #4 did not have a comprehensive care plan developed with interventions for reoccurring urinary tract infections; and Resident #34 did not have a comprehensive care plan developed for wandering risk. Findings include: The facility policy Interdisciplinary Care Plans, dated 4/12/2022 documented the facility must develop and implement a comprehensive care plan to meet the needs of each resident. The plan of care should include individual preferences, desires, and goals of care to meet the resident's medical, psychosocial, and nutritional needs. The interdisciplinary team must maintain the person-centered plan of care and update as indicated with new or changing interventions to achieve the desired outcome. 1) Resident #4 had diagnoses including urinary tract infections and chronic kidney disease. The 1/31/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required substantial/maximal assistance with toileting, and had a urinary tract infection in the last 7 days. The comprehensive care plan last revised 4/21/2023 documented the resident had bladder incontinence related to impaired mobility. Interventions included the resident wore briefs in and out of bed, clean peri-area with each incontinence episode, encourage fluids during the day to promote prompted voiding responses, and incontinence care in morning and evening, before and after meals, and as needed. The 4/7/2024 licensed practical nurse #13 progress note documented the nurse practitioner gave a new order for a urinalysis (physical and chemical examination of urine), and culture and sensitivity (culture checks for bacteria in the urine and sensitivity determines what antibiotics the bacteria are susceptible or resistant to). The 4/15/2024 nurse practitioner #1 progress note documented the resident was seen for a positive urinary tract infection and complaining of burning with urination, suprapubic (lower abdominal) pain, and staff would notify the urology office due to the resident's history of frequent urinary tract infections. They would be starting an antibiotic called Keflex for 7 days. During an observation and interview on 4/22/2024 at 1:52 PM, Resident #4 was seated in their wheelchair in their room. They stated they were taking antibiotics for a urinary tract infection, and they were still having urinary urgency. During an observation and interview on 4/23/2024 at 9:05 AM, Resident #4 was seated in their wheelchair self-propelling around their room. They stated they had burning when they urinated that morning and they had notified licensed practical nurse #14. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 - Few	The 4/25/2024 physician #20 progress note documented they had extended the Keflex (antibiotic) through 5/2/2024 for a urinary tract infection. There was no documented evidence Resident #4's care plan was updated to include a history of frequent urinary tract infections with goals and interventions, including preventative measures and treatment regimens. During an interview on 4/25/2024 at 12:31 PM, licensed practical nurse #13 stated they thought the licensed practical nurse Unit Managers could update a resident's care plan, but a registered nurse had to initiate them. The registered nurse Unit Manager reviewed and updated resident care plans quarterly and they were also updated as needed or when a resident had a significant change. Resident #4 had frequent urinary tract infections, they were on an antibiotic, and they had to monitor the resident closely for reoccurring urinary infections. They stated it was very important to have Resident #4's history of urinary tract infections and active urinary tract infections in their care plan because they happened so frequently and so staff would know to monitor the resident for signs and symptoms of a worsening or active infection. They stated all staff looked at resident's care plans to learn about the resident. If Resident #4's care plan was not updated with accurate information staff would not know how to properly care for them. During an interview on 4/25/2024 at 2:34 PM, registered nurse Unit Manager #4 stated licensed practical nurses could update resident care plans, but a registered nurse had to initiate them. Care plans were reviewed and updated quarterly, annually, and as needed. All staff had access to care plans, and they looked at them to know how to properly care for a resident. Resident #4 had frequent urinary tract infections and was followed by a urologist (a physician that specializes in the diagnosis and treatment of diseases and conditions of the urinary tract and the reproductive system). Resident #4's care plan should have been updated to include their history of frequent infections and how they were started on an antibiotic for an active urinary tract infection. If staff was not familiar with the resident, they would not know about their history or to monitor for signs and symptoms of a urinary tract infection. They stated it was important to update Resident #4's care plan so the resident would receive the best and most accurate care. During an interview on 4/25/2024 at 9:42 AM, the Director of Nursing stated licensed practical nurses could update care plans, but registered nurses were responsible for initiating, reviewing, and updating care plans. Care plans were reviewed quarterly and as needed when changes occurred. If Resident #4 had a urinary tract infection, was on an antibiotic, or had a history of frequent urinary tract infections they expected the care plan to reflect that. It was important to keep Resident #4's care plan updated to tell a story of what was happening with the resident so staff could properly care for them. 2) Resident #32 was admitted to the facility with diagnoses including dementia. The 3/18/2024 Minimum Data Set admission assessment documented the resident had moderate cognitive impairment, did not wander, required supervision/touching assistance to walk 50 feet with two turns, and used a wheelchair and walker in the 7 days prior to the assessment. The undated care instructions documented Resident #32 ambulated with a 2-wheeled walker and minimal assistance of 1. The instructions did include the use of a wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 - Few	The comprehensive care plan initiated 3/13/2024 documented Resident #32 was alert with confusion, able to make needs known, able to ambulate with a 2-wheeled walker and minimal assistance, distance as tolerated, and able to stand pivot transfer with contact guard assistance. Wheelchair use was not documented. The Wandering Risk Scale dated 3/11/2024 documented Resident #32 was comatose or dependent with mobility resulting in a score of 0/low risk. The physical therapy discharge summary dated 4/8/2024, documented the resident received therapy from 3/12/2024-4/8/2024. The resident used a manual wheelchair, required supervision or touching assistance to wheel 50 feet with two turns, and supervision/touching assistance to wheel 150 feet. The summary documented treatment results were communicated to the interdisciplinary team. During an interview on 4/22/2024 at 3:47 PM Resident #32 stated they moved themselves around the building in their wheelchair. The resident stated sometimes they got turned around but staff kept an eye on them. The following observations were made of Resident #32 in their wheelchair: - on 4/22/2024 at 2:00 PM being brought back to the unit by an environmental services staff member who stated the resident was going in the wrong direction. The resident was previously in the dining room having their nails done. - on 4/24/2024 at 9:20 AM entering another resident's room and insisting the other resident was their grandfather. The resident remained in the room for approximately 13 minutes before they self-initiated their exit back into the hall. - on 4/25/2024 at 8:43 AM self-propelling down the main corridor and off their unit. They were brought back to their unit at 8:46 AM by Operations Manager #19 who stated the resident had entered their office and asked for a restroom. There was no documented evidence the resident's care plan reflected the resident's ability to independently propel their wheelchair throughout the facility. During an interview on 4/25/2024 at 11:17 AM, certified nurse aide #10 stated they believed Resident #32 was an elopement risk as they had wandered and gone to the front lobby to sit on the couch. To their knowledge this happened twice, and front lobby staff called the unit to inform them the resident was in the lobby. They stated they were unaware of specific measures in place regarding the resident's wandering. If the resident getting off the unit was not reported, the resident could get hurt or end up outside. During an interview on 4/25/2024 at 12:05 PM licensed practical nurse #9 stated a high-risk elopement resident typically talked about going home, tried to catch a bus, wandered around, and had diminished mental capacity. They observed Resident #32 wander down the wrong end of the hall looking for their room, but they were not aware of the resident getting off the unit without assistance. They stated the resident was not at high risk for elopement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 - Few	During an interview on 4/25/2024 at 12:25 PM, licensed practical nurse Assistant Nurse Manager #7 stated Resident #32 was a wanderer but did not exit seek. They found resident in the lobby, back hallway, and by the Ocean unit. They would consider making the resident a high elopement risk if they verbalized a desire to go home or attempted to leave the building. Therapy or nursing updated mobility status changes on the care plan and on the care instructions. They were not aware of any specific measures in place regarding Resident #32's wandering. During an interview on 4/26/2024 at 10:39 AM, registered nurse Manager #4 stated there were no high-risk elopement residents on the [NAME] unit (the resident's unit). They stated wandering risk assessments were done on admission and quarterly. The therapy department was responsible for updating the care plans for ADLs and mobility. Behavioral care plans were updated by nursing and/or social work. Registered nurse Manager #4 stated Resident #32 had a diagnosis of dementia and had left the unit previously and went as far as the lobby. They stated staff kept an eye on the resident, but no specific interventions were in place. If the resident left the unit without staff awareness staff might panic, and resident could miss a meal or other treatment. 10NYCRR 415.11(c)(1) 50561

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44838 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not review and revise the comprehensive care plan based on changing goals and needs for 1 of 1 resident (Resident #79) reviewed. Specifically, Resident #79's meal tickets and comprehensive care plan included a fluid restriction of 2,000 milliliters daily which was previously discontinued by the medical provider. Findings include: The 4/12/2022 facility policy Interdisciplinary Care Plans documented the interdisciplinary team would maintain a person centered plan of care at all times and update as indicated with new or changing interventions developed to achieve the desired outcome. Resident #79 had diagnoses including chronic kidney disease, peripheral vascular disease (poor circulation), and congestive heart failure (the heart does not pump efficiently). The 4/3/2024 Minimum Data Set assessment documented the resident had intact cognition, required assistance with activities of daily living, and received a therapeutic diet. The comprehensive care plan initiated 12/27/2023 and revised on 1/9/2024 documented the resident had potential compromised nutrition status related to recent hospitalization . Interventions included a regular diet, regular consistency, thin liquids, and a 2,000 milliliter fluid restriction. A 4/18/2024 progress note by nurse practitioner #1 documented the resident stated they no longer wanted their fluid restriction. The resident had full capacity to make the decision and was aware of the risks of nonadherence to a restriction. The 2,000 milliliter fluid restriction was to be discontinued. Staff was to contact medical for more than a 3 pound weight gain. Physician orders documented a 2,000 milliliter fluid restriction was discontinued on 4/18/2024. The resident's 4/26/2024 care instructions documented a regular diet, regular consistency, thin liquids with a 2,000 milliliter fluid restriction. The following observations were made: - on 4/23/2024 at 12:39 PM, the resident's lunch meal ticket documented a fluid restriction of 2,000 milliliters. The resident stated the fluid restriction was removed and they liked ice with their soda. - on 4/24/2024 at 12:24 PM, the resident's lunch meal ticket documented 2,000 milliliter fluid restriction. Certified nurse aide #2 provided the resident a full glass of ice that was not listed on the ticket. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/25/2024 at12:33 PM, the resident's lunch meal ticket documented 2,000 milliliter fluid restriction and did not include ice. The resident requested ice for their soda which was provided by licensed practical nurse #3. During an interview on 4/25/2024 at 1:10 PM, licensed practical nurse #3 stated fluid restrictions were medically ordered. Fluid restrictions were listed on the resident's medication administration record for special instructions, on the meal ticket, and in the care plan. Resident #79 was not on a fluid restriction. The nurse practitioner discontinued it last week, and it was taken out of the computer. When they brought the resident ice at lunch, they noted that it was still on the ticket, but they had not notified any of anyone of the discrepancy. During an interview on 4/25/2024 at 1:13 PM, certified nurse aide #2 stated they found resident care information on the care card in the computer which included fluid restrictions. The fluid restriction for resident #79 had been discontinued. They were notified by nursing, and it was no longer on the care card. When delivering trays, they were supposed to compare the meals ticket to the tray prior to serving to make sure residents received the correct diet. They had noticed the fluid restriction was still on Resident #79's meal ticket, but they had not notified anyone of the discrepancy. During an interview on 4/25/2024 at 2:13 PM, registered nurse Unit Manager #4 stated if a diet order was discontinued the registered dietitian should be notified by nursing or the speech pathologist. If the meal ticket and diet orders did not match it could pose a risk to the resident. A resident could get too many fluids, which could lead to fluid overload or risk for congestive heart failure. During an interview on 4/25/2024 at 2:45 PM, nurse practitioner #1 stated when they discontinued an order it went in the order book, or they gave a telephone order. Nursing changed the order in the electronic health record and communicated to the rest of the team. If a fluid restriction was discontinued, it should not be listed on the meal ticket. Diet orders needed to be accurately communicated to keep residents healthy. Fluid restrictions were important for some residents to prevent fluid overload or exacerbation of congestive heart failure. During an interview on 4/26/2024 at 10:43 AM registered dietitian #5 stated they should have been notified by nursing or the nurse practitioner if there was a dietary change ordered. They should be notified of any change in diet consistency, weight gain or loss, and fluid restrictions. They would then make changes to meal tickets. Staff should make sure meal tickets and trays matched. If there was a discrepancy, they should let the kitchen know. If a resident was on a fluid restriction staff should not provide extra ice if it was not on the meal ticket. The fluid restriction for Resident #79 was discontinued on 4/18/2024 and they were not notified, therefore the meal ticket was not changed. If a fluid restriction was supposed to be in place and was not followed it could lead to hyponatremia (low blood sodium) or increased edema (fluid retention). 10 NYCCR 415.11(c)(2)(iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44838 48675 Based on observation, record review, and interviews during the recertification and abbreviated (NY00310300, NY00321040) surveys conducted 4/22/2024-4/26/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 3 of 5 residents (Residents #2, #12 and #35) reviewed. Specifically, Resident #2 was not assisted with removal of unwanted facial hair; Resident #12 had unclean and untrimmed fingernails; and Resident #35 had unclean fingernails. Findings include: The facility policy Activities of Daily Living (ADL) reviewed 10/1/2023 documented appropriate care, treatment, and services were provided for residents who were unable to carry out activities of daily living independently in accordance with the plan of care, including support and assistance with hygiene, mobility, elimination, dining, and communication. 1) Resident #2 had diagnoses including fracture of the right femur (thigh bone) and need for assistance with personal care. The 4/2/2024 Minimum Data Set assessment documented the resident was cognitively intact, required partial/moderate assistance with showering/bathing, substantial/maximal assistance with personal hygiene, and did not refuse care. The comprehensive care plan revised 3/23/2022 documented the resident had activities of daily living self-care deficits related to activity intolerance. Interventions included sensitive skin pat dry and avoid scrubbing, a sponge bath was provided when a full bath/shower was not tolerated, shower day was on Wednesday during the day shift, and the resident required extensive assistance for bed mobility and bathing/showering. The resident was cognitively intact and able to make all their needs known. The 4/2024 resident care instructions (Kardex) documented the resident required extensive assistance for bathing/showering, complete bath was in the morning and a partial bath in evening, and certified nurse aides should observe skin during routine skin care and report any abnormalities to a licensed practical nurse or registered nurse. Resident #2 was observed: - on 4/22/2024 at 1:13 PM, lying in bed with a significant amount of 1/4 inch long, gray/white hair covering their upper lip and chin. The resident stated they received showers/baths, they did not want facial hair, and the staff did not shave them or offer to shave them. - on 4/23/2024 at 10:08 AM, in their room, seated in their wheelchair with a significant amount of 1/4 inch long gray/white hair covering their upper lip and chin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/24/2024 at 9:51 AM, lying in bed with a significant amount of 1/4 inch long gray/white hair that covered their upper lip and chin. The resident stated they were not going to get out of bed to take a shower due to leg pain and they were still waiting to get cleaned up for the day. At 11:15 AM, certified nurse aide #12 and an unidentified staff member exited the resident's room carrying a plastic bag of dirty linens. The resident was lying in bed wearing a clean gown, with a significant amount of 1/4 inch long gray/white hair that covered their upper lip and chin. The certified nurse aide task report (activities of daily living documentation) documented Resident #2 was dependent for personal hygiene on 4/22/2024 during the day shift and required substantial/maximal assistance with personal hygiene during the day shift on 4/23/2024 and 4/24/2024. During an interview on 4/25/2024 at 12:02 PM, certified nurse aide #12 stated if a resident did not take a shower, they still received a bed bath and personal hygiene. Personal hygiene consisted of haircare, face washing, oral care, and shaving. They provided care to Resident #2 on 4/23/2024, 4/24/2024, 4/25/2024, and they thought they notified licensed practical nurse #13 on 4/24/2024 that the resident refused to be shaved. They stated long facial hair on a female was not dignified. During an interview on 4/25/2024 at 12:14 PM, licensed practical nurse #13 stated personal hygiene consisted of grooming, shaving, oral care, and complete head to toe care. If a resident refused care the certified nurse aide notified them, and they documented the refusal. They stated Resident #2 could have refused their shower due to discomfort, but they were not notified on 4/24/2024 or at all that week that the resident refused care. They stated they did not notice Resident #2's facial hair, it was not okay that it had grown so long, and it was not dignified. During an interview on 4/25/2024 at 2:24 PM, registered nurse Unit Manager #4 stated personal hygiene consisted of grooming including hair care, oral care, and shaving. When a certified nurse aide documented they completed personal hygiene it meant they offered and completed those tasks. If a resident refused care the certified nurse aide documented the refusal in the tasks and notified the medication nurse so they could reapproach the resident. They stated it was not dignified for Resident #2 to have facial hair. During an interview on 4/25/2024 at 9:42 AM, the Director of Nursing stated certified nurse aides were responsible for providing bathing, shaving, grooming, and oral care. If a resident refused care, they expected the certified nurse aide to document the refusal. They stated female residents should not have facial hair for dignity reasons and Resident #2 should have been shaved before their facial hair got so long. 2) Resident #12 had diagnoses including dementia, rheumatoid arthritis (an autoimmune inflammatory disease), and contracture (tightening of tissues causing a deformity) of the right hand. The 3/14/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and was dependent for personal hygiene and bathing. The comprehensive care plan initiated 6/22/2018 and revised 4/25/2024, documented the resident had a self-performance deficit in activities of daily living. Interventions included nurses clipped nails as part of the bathing/showering task and the resident required total assistance for bathing and personal hygiene tasks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated care instructions documented the resident preferred weekly tub baths on Tuesdays during the 6:00 AM-2:00 PM shift and required total assistance with personal hygiene. The certified nurse aide documentation history detail from 4/1/2024 to 4/24/2024 was incomplete with many missing certified nurse aide initials on the evening shift (2:00 PM-10:00 PM) and the night shift (10:00 PM-6:00 AM) indicating personal hygiene was not provided. The shower task was signed as completed every Tuesday on the 6:00 AM-2:00 PM shift except for 4/9/2024 when the code 97/not applicable was used. There were no refusals documented for showers or personal hygiene. Resident #12 was observed: - on 4/23/2024 at 12:37 PM, their right thumb nail was long with brown debris underneath. - on 4/24/2024 at 10:46 AM their fingernails were very long with brown debris under most of the fingernails. The resident's fingernails were observed with licensed practical nurse Assistant Nurse Manager #7. - on 4/25/2024 at 9:29 AM, their fingernails were long and unkept with brown debris underneath. The resident's fingernails were observed with licensed practical nurse #9. - on 4/25/2024 at 10:59 AM, the resident looked at their fingernails and stated their preference was to have their nails shorter. During an interview on 4/25/2024 at 1:50 PM certified nurse aide #10, stated fingernail care was part of the shower task. They stated certified nurse aides could cut both fingernails and toenails if the resident was not diabetic. They stated Resident #12's nails needed to be cut soon as they were long and could dig into skin. During an interview on 4/25/2024 at 2:17 PM licensed practical nurse #9, stated nail care should be done on shower day if the resident allowed. They expected certified nurse aides to trim nails on shower days or report if they did not. If nails were not cared for, they could cause hygiene issues, could contaminate food, cause skin breakdown, and cause the resident to scratch themselves or others and cause an infection. During an interview on 4/25/2024 at 2:28 PM licensed practical nurse Assistant Nurse Manager #7, stated nails should be checked on shower day for grooming and cleanliness. They expected certified nurse aides to trim nails on shower days or report if they did not. Resident #12's nails were unkept on 4/24/2024. They stated good nail care was important for hygiene, infection prevention, and skin integrity. 3) Resident #35 had diagnoses including dementia, need for assistance with personal care, and age-related macular degeneration (disease affecting vision). The 4/11/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required substantial/ maximum assistance with personal hygiene and bathing, and did not reject care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated 9/10/2022 documented the resident had an activity of daily living deficit related to fatigue. Interventions included shower days on Thursday day shift and as needed with extensive assist of 1 and extensive assistance of 1 for personal hygiene/grooming. The resident had a self-feeding difficulty related to being legally blind. Interventions included finger foods. Resident #35 was observed: at the following times in the dining room: - on 4/22/2024 at 10:39 AM seated in their wheelchair at the touch screen sensory table with a dark substance under their fingernails; and at 12:03 PM seated in their wheelchair during the lunch meal picking up their sandwich with a dark substance under their fingernails. - on 4/23/2024 at 8:55 AM and 2:41 PM seated in their wheelchair with a dark substance under their fingernails. - on 4/24/2024 at 11:22 AM, 11:55 AM, and 12:24 PM seated in their wheelchair during the lunch meal picking up their sandwich with a dark substance under their fingernails. - on 4/25/2024 at 8:26 AM seated in their wheelchair during the breakfast meal with a dark substance under their fingernails; and at 1:52 PM seated in their wheelchair with a dark substance under their fingernails. The certified nurse aide documentation history detail for Resident #35 documented: - a shower/ bath and personal hygiene was completed on 4/22/2024 at 1:59 PM by certified nurse aide #15. - personal hygiene was completed on 4/22/2024 at 9:59 PM and 11:44 PM by certified nurse aide #16. - personal hygiene was completed on 4/23/2024 at 10:37 AM by certified nurse aide #15 and at 9:59 PM and 11:32 PM by certified nurse aide #16. - a shower was completed on 4/23/2024 at 9:59 PM by certified nurse aide #16. - personal hygiene was completed on 4/24/2024 at 10:29 AM by certified nurse aide #15. - personal hygiene was completed on 4/25/2024 at 10:30 AM by certified nurse aide #15. A voicemail message was left for certified nurse aide #16 on 4/25/2024 at 12:58 PM. There was no return telephone call. During an interview on 4/25/2024 at 1:56 PM certified nurse aide #18 stated residents' hands were washed on shower days and included nail care. The dark substance under Resident #35's nails was likely fecal matter as the resident had a history of digging into their soiled incontinence brief. They should not be eating finger foods with dirty hands. The resident's hands currently had a dark substance under their fingernails, and they should be cleaned. They did not usually wash the resident's hands before meals, but they should so fecal matter was not being ingested. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 2:06 PM licensed practical nurse #14 stated showers/bathing included cleaning, washing, grooming, oral hygiene, and fingernails were cut and cleaned. Resident #35 was known to dig in their incontinence brief and the dark substance under their fingernails was likely fecal matter. Hands should be wiped with towelettes before meals, but it was rarely done. Documentation on the certified nurse aide activities of daily living indicated the task was completed and they expected if the shower was documented as completed, the resident's fingernails were cleaned and trimmed. During an interview on 4/26/2024 at 10:22 AM registered nurse Unit Manager #4 stated bathing a resident included washing their hands and fingernails. Hands were also washed with morning and bedtime care. Hands should be washed before meals for cleanliness and hygiene. They expected the certified nurse aides to clean fingernails. Resident #35 put their hands in their fecal matter, and they could get sick if they ate a sandwich with contaminated hands. It was especially important to check Resident #35's fingernails before meals because they touched their stool and ate finger foods. Ingesting fecal matter could make them sick. During an interview on 4/26/2024 at 12:08 PM the Director of Nursing stated residents' hands should be cleaned after toileting, before meals, and when soiled. Fingernails were cleaned and clipped with shower days. The activities department also did manicures and asked staff to clip fingernails if they were long. Hand hygiene should be performed on all residents before meals. Eating with dirty hands could make the resident sick. Resident #35 was known to touch their own fecal matter and therefore staff should ensure their hands/ nails were checked and washed before all meals. 10NYCRR 415.12(a)(3) 49448 50561

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50561 Based on observation, interview, and record review during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 1 of 2 residents (Resident #12) reviewed. Specifically, Resident #12 did not have their resting palm (hand) guards applied appropriately as recommended by occupational therapy for hand and finger contractures. Findings include: The facility policy Orthotic Devices reviewed 8/1/2023, documented the facility assured residents received appropriate services and interventions in response to physical and functional needs with the purpose that joint range of motion and elasticity were maintained and provided proper body alignment. Resident #12 had diagnoses including dementia, rheumatoid arthritis (an autoimmune inflammatory disease), and contracture (tightening of tissue) of the right hand. The 3/14/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and was dependent for personal hygiene and dressing. The comprehensive care plan initiated 6/22/2018 and revised 11/02/2018 documented Resident #12 had an activities of daily living self-care performance deficit related to impaired balance. Interventions for contractures included bilateral palm protectors worn on hands, per resident tolerance, and promoted skin integrity. The 12/21/2024 occupational therapist #24 evaluation and plan of treatment documented Resident #12 was referred to occupational therapy for hand contracture management. The resident's bilateral hand contractures limited functional participation in activities of daily living and the resident would benefit from occupational therapy to reduce bilateral contractures. Bilateral (both sides) palm guards were already in use, range of motion was impaired to all 10 digits (fingers), and the resident was dependent with application and removal of palm guards. The 1/3/2024 occupational therapist #24 discharge summary documented the resident was on therapy services from 12/21/2023-1/3/2024 and discharge recommendations were continued use of bilateral palm guards for decreased risk of skin breakdown and promotion of skin integrity. The undated care card (care instructions) documented bilateral palm guards always on except during care delivery. Resident #12 was observed: - on 4/22/2024 at 3:30 PM in bed without bilateral palm guards on. - on 4/23/2024 at 12:37 PM seated in the dining room at a table without bilateral palm guards on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/24/2024 at 9:06 AM seated in the dining room in their chair without bilateral palm guards on. The activities of daily living documentation report for 4/2024 did not include application/removal of bilateral palm guards. During an interview on 4/25/2024 at 1:50PM, certified nurse aide #10 stated if a resident needed splints it was listed on their care card, but it was not usually listed as a task. Resident #12 had the things on their hands and there was a task to be signed off indicating the things were always on except at night when they were removed. On 4/22/2024 they were assigned to the resident and their palm guards were not applied but they may have signed that they were applied. Sometimes the certified nurse aides placed the splints on and other times it was the nurse. The resident's nails were long and could start to dig into their skin and they could get sores, get an infection, and have pain if they did not wear the palm guards. During an interview on 04/25/2024 2:17 PM licensed practical nurse #9 stated certified nurse aides could put splints on, but the nurses ensured it was done. They expected if the certified nurse aides did not apply the palm guard, it was reported to them. Occupational therapy made the recommendations for splints and updated the care plan and care card and then verbally communicated this to the nursing staff. They noticed Resident #12's nails were quite long this morning and when their hands were clenched it could cause a fungal rash. During an interview on 4/25/2024 at 2:28 PM licensed practical nurse Assistant Nurse Manager #7 stated any application of splints showed on the care card and therapy did this. Certified nurse aides applied the splints, and they believed it showed up as a task for the certified nurse aides to sign off. Nurses did not sign for them, but they ensured it was done. They expected if a certified nurse aide did not apply the palm guards it was reported to them. On 4/24/2024 they noticed that Resident #12's palm guards were not in place, and they believed they were to be applied when resident was up and removed when resident was in bed. During an interview on 4/26/2024 at 10:29 AM registered nurse Unit Manager #4 stated physician orders were not needed for palm guards, but it was in the care plan and flowed to the care card. They did not believe Resident #12's palm guards were being signed for as recommendations were only as the resident tolerated. They expected if the resident did not tolerate the palm guards, the certified nurse aides would report it. Any declinations or refusals were probably not documented, but they should be. Application of splints should have been on the treatment administration record and would be going forward. Splints and guards were important as contractures could worsen, and skin could break down. During an interview on 4/26/2024 at 11:15 AM occupational therapist #11 stated when evaluation orders came through, they talked to the nurse and screened the resident based on the area of concern. If a resident was picked up for treatment, they put in an order. They updated care plans with any changes and always linked it to the care card for the certified nurse aides to see. They also verbally communicated any changes directly to the aides and the Nurse Manager. They expected their recommendations for splints/guards to be implemented and carried out. If they were not, the contractures could worsen. 10NYCRR 415.12(e)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 44838 Based on observation, interview, and record review during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure residents maintained acceptable parameters of nutritional status for 1 of 4 residents (Resident #276) reviewed. Specifically, Resident #276 had a significant weight loss, nutritional status and interventions were not reassessed, and there was no documented evidence the medical provider was made aware of the significant weight loss. Findings included: The facility policy Residents Weights /Height and Significant Weight Loss last reviewed 10/25/2022, documented regular monitoring of weights was necessary to screen residents for significant weight changes, which may indicate a resident was at nutritional risk. Each resident weight and height were measured upon admission (within 48 hours). The height and weight were recorded into the electronic medical record. New admissions were weighed weekly for 4 weeks. The Unit Manager/Charge Nurse would review the weight and determine if a reweight was indicated. Nursing would indicate verified weight decreases or increases on the 24-hour report. Weights would be entered into the electronic medical record each week by designated staff. The nutritional needs and intake of the residents with a significant weight loss would be assessed by the dietitian. Appropriate interventions and recommendations would be documented in the electronic medical record (in a progress note or assessment) as well as on the resident's care plan. Resident # 276 had diagnoses including dysphagia (difficulty swallowing), dementia, and moderate protein-calorie malnutrition. The admission Minimum Data Set assessment was in progress and not completed. A 4/17/2024 physician order documented the resident's diet order was a regular pureed texture solid diet with pudding thick liquids. The 4/17/2024 admission assessment/base line care plan completed by registered nurse #4 documented both the resident's admission height and weight were to be obtained in house within 24 hours of their admission, the resident was confused with both short and long term memory problems, had a special diet, wore dentures, no edema was present, required some assistance by staff for activities of daily living including eating, and planned to discharge back to assisted living. The comprehensive care plan initiated 4/18/2024 documented an activity of daily living self-care performance deficit related to generalized deconditioning. Interventions included setup for eating. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/2024 at 2:59 PM, registered dietitian #5 documented the resident was admitted status post hospitalization , was able to answer very basic yes or no questions and had no known food allergies. They were able to feed themself after set-up. Food and fluid preferences were reviewed, and they did not drink milk. Due to their diet consistency milk was replaced at meals with a 4-ounce Magic Cup (nutritional supplement) three times daily. The speech language pathologist evaluated the resident on 4/18/2024 and recommended continuation of pureed solids and pudding thick liquids. The resident met the criteria for moderate protein-calorie malnutrition as evidenced by loss of muscle mass and loss of fat stores. Admission height and weight were pending. The resident was placed on weekly weights to determine a baseline weight. The 4/18/2024 occupational therapist #24 evaluation and plan for treatment documented clinical impressions/reason for skilled services were the resident presented with impairments in balance, dexterity, fine motor coordination, gross motor coordination, strength and mobility resulting in limitations and/or participation restrictions in the areas of mobility and self-care. The resident required setup or clean up assistance for eating. The 4/18/2024 speech language pathologist #27 evaluation and treatment documented during the evaluation, the resident was seen consuming a meal of pureed solids and pudding thick liquids. Minimal assistance was needed with loading utensils, although the resident was able to load utensil throughout meal. The recommendation was to continue the current diet of pureed solids with pudding thick liquids, implementation of skilled speech therapy to address dysphagia, assess least restrictive diet, and assess ability for further diet upgrades. Recommendations included the resident should be out of bed and upright at all meals; and required full supervision and assistance at mealtime. The unit weekly weight sheet, located in a binder in the nursing office on the unit, documented the resident weighed 105.5 pounds on 4/18/2024 and 90 pounds on 4/22/2024, a loss of 15.5 pounds/ 14.69% in 4 days. The method of weight measurement was listed as chair, with the chair weight documented at 36.7 pounds with no pedals. There was no documented evidence registered dietitian #5 assessed the resident's nutritional needs or reviewed the nutritional plan of care when the resident had a significant weight loss of 14.69%from 4/18/2024 to 4/22/2024. There were no documented nursing notes from 4/18/2024-4/21/2024 and no documented evidence the medical provider was notified of the resident's significant weight loss. The resident's electronic medical record documented a weight of 90 pounds on 4/22/2024. There were no other weights documented in the electronic medical record. Resident #276 was observed: - on 4/22/2024 at 12:10 PM, seated at a table in the dining room with a puree solids and pudding thick liquid meal in front of them, no staff assistance was provided. - on 4/23/2024 at 12:26 PM, seated in the dining room, not eating their meal, and staff did not offer encouragement or assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/24/2024 at 9:37 AM, being assisted with breakfast by speech language pathologist #27. The meal intake was less than 25%. - on 4/24/2024 at 12:59 PM, eating independently without staff assistance or encouragement. They consumed 50% of rice pudding, 50% of their Magic Cup (nutritional supplement), and drank 50% of their apple juice. A 4/24/2024 physician order documented the resident's diet order was changed to regular pureed texture solids with nectar thick liquids. The comprehensive care plan initiated 4/18/2024 and revised 4/24/2024 documented the resident had chewing/swallowing difficulty related to dysphagia, inadequate oral intakes related to confusion, and met the criteria for moderate protein-calorie malnutrition. Interventions included regular pureed consistency solids and nectar thick liquids, monitor weights, and intakes. The resident's intake and output and percent consumption report documented fluid intake from 4/18/2024-4/25/2024 was 20-600 milliliters daily, and solid food intake was 25% or less for all meals. A 4/24/2024 registered dietitian #5 progress note documented due to change in consistency the Magic Cup at meals would be changed to an 8 ounce milkshake. Follow up as needed. There was no documented evidence the resident's nutritional needs were assessed or the nutritional plan of care was updated when the resident had a significant weight loss of 14.69% from 4/18/2024 to 4/22/2024 with poor intake. During an interview on 4/25/2024 at 1:30 PM, speech language pathologist # 27 stated the resident was screened on admission and picked up for therapy. They worked with the resident to advance their diet to nectar thick liquids. The goal was for the least restrictive diet, and they were now trying to advance solids. The resident had been reluctant to self-load spoons and feed themself, they were doing better with nectar thick fluids, and drinking independently. Staff encouragement could benefit resident intakes. They were not sure if the resident had a weight loss. The resident did receive nutritional supplements. At the lunch meal today, the resident had 2 bites of pasta and a yogurt. They did not inform anyone of the resident's intakes. During an interview on 4/25/24 at 1:58 PM, registered nurse Unit Manager# 4 stated they were not aware of the resident's 15-pound weight loss since admission. There were no reweights or weight notifications found in the electronic health record. There was no documentation in the acute book (communication book) notifying the nurse practitioner of the resident's weight loss. Certified nurse aides documented intakes and should notify the nurse if they noted poor intakes. The electronic health record documented intakes for Resident # 276 no greater than 25% since admission. If they were aware they would have notified the registered dietitian and nurse practitioner about the resident's weight loss and intakes at meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/25/2024 at 2:20 PM, ward clerk #29 stated certified nurse aides obtained weights and entered them in the weight book. A nurse or the ward clerk would then enter the weights in the electronic health record. If there was a 3-pound difference from the previous weight, a reweight was needed. An admission weight was supposed to be obtained to establish a baseline weight. They would notify nursing if there was a weight loss or gain greater than 3 pounds. Resident #276 had a weight loss of 15 pounds in 4 days documented on the unit weight sheet. They were not sure if a reweight was done. A reweight should have been obtained and the registered dietitian and nurse practitioner should have been notified. During an interview on 4/25/2024 at 2:33 PM, occupational therapist # 24 stated they screened the resident on admission. The resident was observed during lunch and was able to self-feed without assist or cueing. They did eat slow, and they did not stay for whole meal. If staff on the unit noted repeated poor intakes, they should notify occupational therapy for a reassessment. The resident could need initiation cues or encouragement. During an interview on 4/25/2024 at 2:50 PM, nurse practitioner #1 stated weights were documented in a weight book. There was an acute book for issues that staff could write in if it needed their attention. If there was a weight gain or loss of 3 pounds or greater, they should be notified either in the book, by email, or phone. A weight loss of 15 pounds should have been documented in the book for their attention. They were unaware the resident had a 15-pound weight loss since admission. If they were made aware they would have assessed the resident, ordered labs, additional fluids if needed, or started the resident on an appetite stimulant. During an interview on 4/26/2024 at 10:11 AM, registered dietitian #5 stated on admission they reviewed the hospital paperwork, interviewed the resident, and asked about appetite, and chewing or swallowing problems. They also asked the resident if they were able to feed themselves, if they had any food preferences or allergies, their weight history, and usual body weight. Weights were obtained on admission within 48 hours by nursing and documented in the weight book and then put in the electronic health record by the ward clerk. Admission weights were important to determine a baseline weight, it helped to determine the resident's nutritional needs. Nursing staff was supposed to notify them of any weight change of greater than 3 pounds in a week and they would then double check if a reweight was obtained and reassess the resident's needs if needed. Timely notification of weight changes was important to put interventions into place. They would want to be made aware if the resident was not eating. The nurse practitioner should also be notified of weight changes and residents who were not eating well at meals so they could be assessed and reviewed for possible medication changes or the need for additional fluids. They were not aware an admission weight of 105 pounds was documented for the resident and not entered into the electronic medical record. The initial admission note was written on 4/18/2024 and there was no admission weight documented at that time in the electronic medical record. The 4/22/2024 weight of 90 pounds was the only weight in the electronic health record, so they were unaware of the 15-pound weight loss. Nursing did not communicate the 15-pound weight loss to them. On 4/25/2024 a weight of 95.6 pounds was recorded and this indicated a significant weight loss of 10-pounds in 6 days. They had not reviewed the resident's meal and fluid intakes prior to learning about the weight loss. They stated occupational therapy should have been notified to determine the need for reassessment of feeding assistance. 10NYCRR 415.12(i)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 49448 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure that a resident being fed by enteral means (tube placed in the stomach for feeding) received the appropriate treatment and services to prevent complications of enteral feed including but not limited to aspiration (inhalation of food/fluid into the lungs) for 1 of 1 resident (Resident #82) reviewed. Specifically, Resident #82's head of the bed was not elevated during and after receiving enteral feedings as ordered. Findings include: The facility policy Enteral Tube Feeding via Continuous Pump revised 6/6/2022 documented the facility remained current in and followed accepted best practices in enteral nutrition. The head of the bed was positioned at 30 degrees-45 degrees (semi-Fowler's position) for feeding, unless medically contraindicated. Resident #82 had diagnoses including adult failure to thrive, gastrostomy (tube inserted in the stomach for feeding) status, and moderate protein-calorie malnutrition. The 2/8/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not have a swallowing disorder, had significant weight loss, was on a prescribed weight gain regimen, and had a feeding tube. The comprehensive care plan initiated 8/31/2023 and revised on 11/6/2023 documented the resident required tube feeding related to an inability to meet their needs orally. The goal was to be free of aspiration. Interventions included monitor, document, and report signs/symptoms of aspiration. The 8/31/2023 physician orders documented: - Tube feeding care: head of bed to be elevated 45 degrees during feeding and for 30 minutes after feeding. Head of bed to be elevated 30 degrees at all other times when feeding not running. - Tube feeding order: full strength Vital AF 1.2 (tube feeding formula), Rate: bolus, Duration: 237 milliliters four times daily, total product volume: 948 milliliters total in 24 hours. - Tube feeding flushes: 60 milliliters of water with each feeding: 30 milliliters before and 30 milliliters after feedings. The 4/2024 Medication Administration Record documented Resident #82 received daily tube feedings at 6:00 AM, 10:00 AM, 5:00 PM and 9:00 PM. The 4/2024 Treatment Administration Record documented from 4/22/2024-4/26/2024 on the day, evening, and night shifts the head of the bed was elevated 45 degrees during feeding and 30 minutes after feeding and the head of bed was elevated 30 degrees at all other times when the feeding was not running. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/23/2024 at 12:28 PM and at 3:13 PM Resident #82 was lying supine (flat on their back) in bed and the head of the bed was not elevated. They stated they received bolus tube feedings four times a day. During an observation on 4/25/2024 at 9:47 AM licensed practical nurse #8 had just completed administering the resident's tube feeding. Licensed practical nurse #8 provided the resident with their bed controls and positioned the head of the bed flat. The nurse asked them if they needed anything else, shut the door, and exited the room. During an interview on 4/25/2024 at 9:47 AM licensed practical nurse #8 stated the head of the bed should not have been flat but instead elevated following the tube feeding. They stated if the head of the bed was flat it increased the chances the resident could get aspiration pneumonia (pneumonia caused by food/fluid in the lungs) and end up hospitalized . This was part of the tube feeding orders and was signed off on the treatment administration record. They stated they should have reminded the resident to keep the head of the bed elevated. During an interview on 4/25/2024 at 10:01 AM licensed practical nurse Assistant Nurse Manager #7 stated after tube feeding the head of the bed should be elevated so the resident did not get back flow of the feeding that could cause pneumonia and possibly hospitalization . They expected nurses to know this and follow the tube feeding orders. If there was regurgitation (back flow) of the tube feeding the resident could become distressed. The resident could develop shortness of breath or abdominal pain. During an interview on 4/26/2024 at 10:17 AM registered nurse Unit Manager #4 stated aspiration precautions meant the head of the bed was elevated 45 degrees. The head of the bed should be elevated during feeding and up to an hour after the feeding depending on the medical orders. This prevented the tube feeding from going into the resident's lungs and developing aspiration pneumonia. Resident #82 was compliant with this but had pain the past couple of days and decreased compliance with the positioning. They expected if the nurse saw the resident lying flat in bed, they would provide education to the resident on the importance of the head of the bed being elevated and encourage compliance. During an interview on 4/26/2024 at 12:08 PM the Director of Nursing stated residents on tube feedings should always have the head of the bed elevated as it prevented aspiration. They stated if the head of the bed was not elevated, the resident could get pneumonia. They expected the nurses to know this as they were educated upon hire and annually thereafter. They stated if licensed practical nurse #8 saw the head of the bed flat, they expected them to elevate the head and encourage the resident to keep the head of the bed elevated. 10NYCRR 415.12(g)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 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. 49448 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and included the expiration date when applicable for 2 of 3 medication carts (Rodeo Drive and Wall Street Unit medication carts) reviewed; and for 2 of 3 medication refrigerators (Rodeo Drive and Wall Street Units) reviewed. Specifically, the Wall Street medication cart had an insulin pen for Resident #3 that was not labeled with an opened or expiration date; and the Rodeo Drive medication cart had an inhaler for Resident #29 that was not labeled with an opened or expiration date, and the medication cart was left unattended and unlocked at the nursing station. Additionally, the Rodeo Drive and Wall Street medication refrigerators did not have consistent documentation that temperatures were monitored or maintained; and the Wall Street medication refrigerator temperature was not maintained within acceptable storage parameters. Findings include: The facility policy Medication Preparation, Administration, Documentation and Storage- General Guidelines dated 5/15/2023 documented multi-dose medications were initialed and dated when opened per pharmacy recommendation. The facility policy Insulin Administration dated 5/4/2023 documented after insulin was removed from the storage point, the expiration date was checked. If a new vial was opened, the expiration date and time were recorded on the vial per manufacturer's recommendations for expiration after opened. Insulin pens must be labeled with the resident's name, the expiration date; and the date it was first opened. The facility policy Medication Room Refrigerator dated 5/20/2022 documented the refrigerator temperature was taken and recorded daily and building services was notified if the temperature reading fell outside of 36-46 degrees Fahrenheit. Each morning the medication nurse checked the temperature of the medication room refrigerator using the thermometer located in each refrigerator. The date was recorded on the medication refrigerator worksheet form. If the temperature fell below 36 degrees Fahrenheit, a work request was completed. Building services recorded on the refrigerator worksheet that the refrigerator was checked if they were notified a problem existed. The medication refrigerator temperature was always kept between 36-46 degrees Fahrenheit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/23/2024 at 1:04 PM with licensed practical nurse #3, the Wall Street medication cart had an open Lantus (long-acting) insulin pen for Resident #3 that was not dated with an open or discard date. The nurse stated the open date was important because insulin expired 28 days after it was opened. Expired insulin may not work as well and may not control the resident's blood sugars as intended. The nurse that opened the insulin should have dated it and the expiration date should always be checked prior to any medication being administered. Following the medication cart observation, the Wall Street medication room was observed. The medication refrigerator temperature log had dates without a reading and readings that were not in the appropriate temperature range (36 degrees to 46 degrees Fahrenheit). The April 2024 log documented temperatures below the appropriate range from 4/1/2024-4/5/2024, no documentation from 4/6/2024-4/7/2024, below the appropriate range from 4/8/2024-4/11/2024, no documentation from 4/12/2024-4/13/2024, below the appropriate range from 4/14/2024-4/15/2024, no documentation on 4/16/2024, below the appropriate range from 4/17/2024-4/19/2024, no documentation from 4/20/2024-4/21/2024, and below the appropriate range from 4/22/2024-4/25/2024. Licensed practical nurse #3 stated the night shift nurse checked the medication refrigerator temperatures and they were not sure what the appropriate temperature range was. During an observation and interview on 4/23/2024 at 1:18 PM the Rodeo Drive medication cart was against the wall of the nursing station and unlocked. Licensed practical nurse Assistant Nurse Manager #7 stated medication carts were supposed to be locked when not in use and should be locked anytime the nurse walked away. If it was not locked, residents could take medications out and ingest them and they could get sick. Residents could also get injured by something sharp in the cart such as a needle. The medication cart contained an opened budesonide- formoterol inhaler (prevents and treats difficulty breathing) for Resident #29 that did not have an open or discard date. The nurse stated they administered the inhaler to Resident #29 that morning without knowing if it was expired. Without an open date, there would be no way of knowing if the inhaler was expired. If the inhaler was expired, it could be less effective. They were not sure how long the inhaler was good for after opened. The resident should not have received that medication because the expiration date was unknown and therefore the medication may not be as effective. The pharmacy delivered medications twice a day so there was no reason a resident should receive an expired medication. The faxed pharmacy recommendation received on 4/26/2024 documented budesonide formoterol inhalers should be discarded 3 months after they were removed from their foil pouch. During an interview on 4/23/2024 at 1:27 PM registered nurse Unit Manager #4 stated insulin pens needed a date when opened because insulin expired 30 days after opened. The nurse that opened the insulin was responsible for dating it when opened. Any nurse that administered insulin should check the date on the pen and ensure the medication was not expired. Expired medications may not be as effective and therefore may not have the desired effect on blood sugars. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/23/2024 at 1:43 PM with licensed practical nurse Assistant Nurse Manager #7, the Rodeo Drive medication room the April 2024 medication refrigerator temperature log had dates without a temperature reading. The contents of the refrigerator included two glargine (long-acting) insulin pens for Resident #21, two lispro (short acting) insulin pens for Resident #106, two Arexvy (respiratory virus vaccine) vials for Resident #82, two Retacrit (treats anemia from kidney disease) vials for Resident #29, six Trulicity (treats diabetes) pens for Resident #57, two Trulicity pens for Resident #43, three Trulicity pens for Resident #30, one stock box of acetaminophen (Tylenol) suppositories, and two boxes of stock bisacodyl (laxative) suppositories. The nurse stated the night shift nurses were responsible for checking the refrigerator temperatures. They stated the log did not have temperatures documented for 4/4/2024, 4/8/2024, 4/12/2024, 4/16/2024, 4/17/2024, 4/21/2024, and 4/22/2024. If the appropriate temperature was not maintained, it could affect the integrity and effectiveness of the medications stored inside. Medications should not be given if appropriate temperatures were not maintained. This could harm the resident. There was no double check that medication refrigerator temperatures were maintained but they thought registered nurse Unit Manager #4 checked them monthly. Without a daily check there was no way of knowing if medications were stored appropriately and were safe to use. During an interview on 4/23/2024 at 1:48 PM registered nurse Unit Manager #4 stated they were not sure what the appropriate medication refrigerator temperature was. The night nurse was responsible for checking and documenting the temperatures on the log sheet. Medications needed to be stored in a specific temperature range to maintain efficacy. If a refrigerator temperature was out of range, maintenance was notified, and a work order was placed. The days the temperature was not logged, there was no way of knowing if the medications were stored properly. There was no documented maintenance notification of medication refrigerator issues for April 2024. During a follow up interview on 4/25/2024 at 12:34 PM registered nurse Unit Manager #4 stated the medication carts should be locked when not in use so that others including residents did not have access to the carts. Only the nurse on duty should have access to the medication cart. If someone ingested the medications, they could become ill. When a new inhaler was opened the date opened should be documented. They stated an inhaler was only good for 30 days after it was opened. The nurse should check the dates on the medications prior to administering. If the inhaler was not dated, it should not have been used and disposed of. The medication would not be as effective if it was expired. 10NYCRR 415.18(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 34459 Based on observation, interview, and record review during the recertification survey conducted 4/22/2024-4/26/2024, the facility did not ensure a policy and procedure regarding the use and storage of food brought to residents from outside the facility to ensure safe and sanitary storage, handling, and consumption for 2 of 6 resident units (Broadway and Rodeo units) reviewed. Specifically, staff did not know the policy and procedure to properly reheat, and measure temperatures of food brought to residents from outside the facility. Additionally, there was undated resident food in the Broadway and Rodeo Unit kitchenette refrigerators. Findings include: The facility policy Food from Outside Sources revised 4/10/2024, documented: - Safe food handling practices were to be followed by visitors and staff regarding handling, storage, and reheating of food brought in from the outside. - It was the responsibility of the person bringing food in for the resident to assure that items were handled properly. - Any staff or visitor may heat food items in a closed, microwave safe container. A microwave was available in each unit pantry. - All containers must be labeled and dated. It was the responsibility of the person placing food in the refrigerator to ensure proper labeling/dating. Food would be discarded if it was not appropriately labeled and dated with resident's name and date of placement in the refrigerator. - The Food from Outside Temperature Log should be completed when reheating food for residents. This form was located near the microwave in each pantry. - Food thermometers were available on the nursing units. Once used, the thermometer would be washed and placed back in the sanitizing solution. - Unconsumed food would be disposed of consistent with manufacturer guidelines, food labels, or upon evidence of spoilage. Disposal of food items would occur after 3 days. The policy did not include recommended temperatures the food should be reheated to. During an observation on 4/22/2024 at 11:12 AM, the Broadway kitchenette refrigerator had an undated take-out container with a resident's name on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/2024 at 1:54 PM licensed practical nurse #3 stated nursing staff should label any food items that were brought in from the outside and placed in the refrigerator or freezer. The certified nurse aides typically reheated any food items for the residents. There was a thermometer on the unit used to check the food temperatures, but they were unsure what the proper reheating temperature was. Staff should check the food to make sure it felt hot enough. They did not recall if they had received any training on reheating food. They stated any food brought in from the outside could only be kept in the refrigerator for 3 days. During an observation on 4/23/2024 at 9:20 AM the Rodeo kitchenette refrigerator had an undated plastic container of chicken and an undated container of sliced mixed fruit. During an interview on 4/23/2024 at 9:20 AM licensed practical nurse Assistant Manager #7 stated the food in the refrigerator was for the residents on both the Rodeo and Broadway units. They contained food items brought in from the outside. All items should be labeled with the resident's name and the date when it was brought in. A thermometer was kept at the nursing station, but they were unsure what temperature food needed to be reheated to. They were also unaware if staff had been trained on how to reheat food items. During an observation on 4/23/2024 at 3:35 PM, the kitchenette refrigerator on the Broadway unit contained 1 undated submarine sandwich. During an interview on 4/24/2024 at 12:59 PM the Food Service Director stated nursing staff was responsible for ensuring resident food brought to the facility from the outside was labeled and dated. Nursing staff should have been trained during orientation on how to reheat the food and what temperature it needed to be reheated to. All the nursing units had a thermometer at the nursing station to check the temperature of the food. Food items, except those with expiration dates, should be discarded within 3 days or 72 hours of being brought into the facility. During an interview on 4/24/2024 at 1:26 PM, certified nurse aide #26 stated they had not received any training on reheating resident's food items and was unsure what temperature food needed to be reheated to. During an interview on 4/24/2024 at 1:30 PM registered nurse Unit Manager #4 stated staff received education on reheating food during their orientation. Each unit had a thermometer at the nursing station. Staff should check the internal temperature of food items that were reheated to ensure they reached 165 degrees Fahrenheit. Food should only be kept in the refrigerators for 3 days unless it had an expiration date on the container. During an interview on 4/24/2024 at 1:44 PM registered dietitian #5 stated any food items brought in from the outside should be labeled with the resident's name and the date it was brought in. Food should be discarded after 3 days or 72 hours unless it had an expiration date. They thought nursing staff received training during orientation on the procedure for reheating food items. Each nursing unit had a reheating food policy. 10NYCRR 415.14(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44838 49448 Based on observation, record review, and interview during the recertification survey conducted 4/22/2024-4/26/2024, 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 communicable diseases and infections for 7 of 8 residents (Residents #17, #22, #33, #82, #89, #267, and #278) reviewed. Specifically, -Resident #17 had clostridioides difficile (a contagious germ that causes diarrhea and inflammation of the colon) and transmission-based precautions were not implemented timely. - Resident #22 had extended-spectrum beta-lactamase (enzyme resistant to most antibiotics) in the urine and transmission-based precautions were not properly maintained. - Resident #33 had colonized extended-spectrum beta-lactamase in the sputum and enhanced barrier precautions were not properly maintained. - Residents #82 and #278 had indwelling medical devices and were not placed on enhanced barrier precautions as required. - Residents #89 and #267 had wounds and were not placed on enhanced barrier precautions as required. Additionally, licensed practical nurse Assistant Nurse Manager #7, licensed practical nurse #8, and certified nurse aide #28 did not perform appropriate hand hygiene. Findings include: The facility policy Enhanced Barrier Precautions reviewed 1/17/2023 documented enhanced barrier precautions required staff to wear a gown and gloves while high-contact care activities were performed. This included residents who were known to be infected or colonized with a multi-drug resistant organism, and residents with indwelling medical devices including but not limited to, urinary catheters, feeding tubes, and wounds. High-contact resident activities included bathing/showering, transfers, hygiene, changing bed linens, changing briefs, assisting with toileting, care of an indwelling medical device, and wound care. The gown and gloves used during high-contact activities were removed and discarded after each resident care encounter. Hand hygiene was performed, and a new gown and gloves were placed before caring for a different resident. An enhanced barrier precautions sign was placed outside the resident's room and gown and gloves were available outside the resident room and alcohol-based hand rub was available both inside and outside the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Contact/ Droplet Precautions (Transmission-Based Precautions) dated 8/15/2023 documented personal protective equipment was recommended for healthcare workers before entering the room of suspected or confirmed infection. Direct contact transmission involved skin to skin contact between residents and staff or between resident to resident. Indirect contact transmission involved contact of employees or residents with contaminated objects in the resident's environment. A sign was placed outside the resident's room and indicated what type of personal protective equipment needed to be worn before the room was entered. An isolation caddy that contained the appropriate personal protective equipment was placed outside the resident's room. Hands were washed immediately after personal protective equipment was removed. Contact precautions applied to important organisms that included (but not limited to) clostridioides difficile. The facility ensured the residents care plan indicated the type of precautions implemented for the resident. 1) Resident # 17 had diagnoses of enterocolitis (inflammation of the intestines) due to clostridioides difficile. The 11/14/2023 Minimum Data Set assessment dated documented the resident was cognitively intact, was dependent for toileting hygiene, and was always incontinent of bowel. The comprehensive care plan initiated 10/10/2023 and revised on 11/16/2023 documented the resident had an activity of daily living self-care performance deficit related to left femur (leg) fracture, right femur infection after surgical repair. Interventions included toileting with extensive assist of one. Physician orders documented: - On 4/22/2024- stool specimen for clostridioides difficile - On 4/23/2024- contact precautions for clostridioides difficile. The comprehensive care plan did not include transmission based precautions. During an observation on 4/24/2024 at 11:42, a contact precaution sign was posted at the entrance of Resident #17's room. Certified nurse aide #28 placed a gown and gloves on prior to entering Resident #17's room with a lunch tray. The certified nurse aide removed the gown and gloves and left the room, did not perform hand hygiene, and entered another resident room to answer a call light. At 12:42 AM certified nurse aide #28 entered Resident #17's room without applying personal protective equipment, picked up the lunch tray, and handed it to licensed practical nurse Assistant Nurse Manager #7 who was not wearing gloves. Licensed practical nurse Assistant Nurse Manager #7 took the lunch tray, placed it in the storage cart, and went to the medication cart and did not perform hand hygiene. Certified nurse aide #28 exited the resident's room and did not perform hand hygiene. An interview was attempted on 4/26/2024 at 9:50 AM with certified nurse aide #28. They were unavailable for an interview. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/26/2024 at 10:12 AM licensed practical nurse #9 stated there was a binder that contained precaution signs and the sign was posted outside the resident room and listed the type of personal protective equipment needed to enter the room. Clostridioides difficile precautions were contact precautions and required the use of gloves and gown. Hands needed to be washed with soap and water. Precautions were important to prevent the spread of infection and should be initiated once infection was suspected. It was not appropriate to wait for the results of a stool specimen before someone was placed on transmission-based precautions. During an interview on 4/26/2024 registered nurse Unit Manager #4 stated if someone was on transmission-based precautions there was a sign and a caddy that contained personal protective equipment outside the resident's room. Clostridioides difficile required the use of gown and gloves, and hands should be washed with soap and water before entering the resident's room and upon exiting the room. Contact precautions should have been initiated for Resident #17 when the stool specimen was ordered. Resident #17 had an order for a stool specimen on 4/22/2024 and the specimen was sent the same day. It was not acceptable that transmission-based precautions were not implemented until 4/23/2024. The resident had a history of recurrent clostridioides difficile. During an interview on 4/26/2024 at 12:11 PM Infection Preventionist #30 stated transmission-based precautions were implemented as soon as a communicable disease was suspected, even if test results were pending. The nurse was responsible to make sure that precautions were implemented and the signage for the precautions was put up outside the resident's room. The care plan should have been updated. Resident #17 should have had precautions implemented immediately upon the order for a stool culture. 2) Resident #89 had diagnoses including a pressure ulcer of the left buttock. 4/9/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent for all activities of daily living, and had one Stage 2 (partial thickness skin loss) pressure ulcer. The comprehensive care plan initiated 4/3/2023 and revised 4/25/2024 documented the resident had potential for compromised skin integrity related to incontinence and currently had a Stage 2 pressure ulcer. Interventions included treatments as ordered and policies/ protocols for skin breakdown prevention/treatment were followed. The care plan did not document enhanced barrier precautions. The 4/9/2024 physician order documented left inner buttocks, cleanse with wound cleanser, apply hydrogel (treatment that absorbs water), cover with a dry protective dressing daily and as needed. The physician orders did not document enhanced barrier precautions. During a dressing change observation on 4/25/2024 at 8:13 AM, licensed practical nurse Assistant Nurse Manager #7, licensed practical nurse #14, and certified nurse aide #18 assisted with Resident #89's pressure ulcer dressing change and all wore gloves. Assistant Nurse Manager #7, licensed practical nurse #14, and certified nurse aide #18 did not wear gowns. 3) Resident # 82 had diagnoses including an open wound, gastrostomy (feeding tube), and pseudomonas (a germ that can cause infections). The 2/8/2024 Minimum Data Set assessment documented the resident was cognitively intact, had an indwelling urinary catheter, received tube feedings via percutaneous endoscopic gastrostomy (tube in the stomach for feedings), and had a wound infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan initiated on 8/31/2023 documented the resident required tube feeding related to an inability to meet their needs orally. Interventions included dependance on tube feeding and water flushes. Resident had an indwelling catheter related to neurogenic bladder (lack of bladder control related to a brain, nerve, or spinal cord problem). Interventions included signs and symptoms of urinary tract infection were monitored, recorded, and reported to the physician. A revision on 4/25/2024 documented the resident had a Stage 2 pressure ulcer (partial thickness skin loss) to their sacrum (tailbone) and was to be seen by the wound nurse. The care plan did not document enhanced barrier precautions. Physician orders documented: - on 9/15/2023 cleanse around percutaneous endoscopic gastrostomy site and place split gauze twice daily and as needed. - on 1/16/2024 Foley catheter for neurogenic bladder, Size 18 French/10 cubic centimeter balloon, change every 6 weeks as needed for neurogenic bladder. - on 4/23/2024 apply skin prep (skin protectant) and Optifoam (wound dressing) to sacrum every day and as needed until healed every day shift for pressure ulcer- wound healing. The physician orders did not document enhanced barrier precautions. The following observations were made: - on 4/24/2024 at 8:58 AM, the resident was in bed, licensed practical nurse #8 was in their room standing next to their bed and stated they had just finished washing the resident's hair. The nurse was not wearing any personal protective equipment and proceeded to exit the resident's room and did perform hand hygiene. - on 4/25/2024 at 9:15 AM during a wound dressing observation, licensed practical nurse #8 entered the resident's room and did not perform hand hygiene. At 9:16 AM the nurse left the room, gathered additional supplies, and reentered the room, without performing hand hygiene. At 9:17 AM, the nurse left the room, gathered additional supplies, and reentered the room, and did not perform hand hygiene. - on 4/25/2024 at 9:32 AM during a tube feeding administration observation, licensed practical nurse #8 entered the resident's room and did not perform hand hygiene. At 9:35 AM, the nurse put their hair up in a ponytail. At 9:36 AM the nurse left the room, gathered additional supplies, reentered the room, and did not perform hand hygiene. The nurse put on gloves, did not put on a gown, administered the tube feeding, and did perform hand hygiene when exiting the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335546	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Home for Central New York Inc	4290 Middle Settlement Road New Hartford, NY 13413

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/2024 at 9:50 AM licensed practical nurse #8 stated they did not know what the stop sign on Resident #82's electronic medication administration record and the electronic treatment administration record with the letters IPC was for. They guessed it stood for infection prevention and control but did not know why it was there. The resident was at increased risk for infection because they had an indwelling urinary catheter and a feeding tube. They were unsure what enhanced barrier precautions were but thought it was related to the skin being monitored and moisturized. Hand hygiene was supposed to be performed upon every entrance and exit of every resident room to prevent the spread of infection. Personal protective equipment was only worn if a resident had an active infection. During an interview on 4/25/2025 at 10:01 AM licensed practical nurse Assistant Nurse Manager #7 stated Resident #82 was at increased risk for infection due to the feeding tube, the urinary catheter, and now the new open wound and they thought that increased hand hygiene was appropriate. They were unsure what enhanced barrier precautions were but thought maybe it was for infection in the urine. Hand hygiene should be performed in and out of every resident room, every time and this was important for decreasing the transmission of infection. During an interview on 4/26/2024 at 10:17 AM registered nurse Unit Manager #4 stated hand hygiene prevented the spread of infection and should be performed every time they entered and exited a resident room. This was for resident and staff safety. Enhanced barrier precautions were for residents with feeding tubes, catheters, ostomies, or non-healing ulcers. This was new and a policy was currently being developed. During an interview on 4/26/2024 at 12:08 PM the Director of Nursing stated hand hygiene prevented the spread of infection and should be performed every time staff entered and exited a resident room. High risk infection activities included dressing changes, tube feedings, and catheter care. Hand hygiene was performed whether gloves were worn or not. Enhanced barrier precautions were new, and a policy was being developed. During an interview on 4/26/2024 at 12:11 PM Infection Preventionist #30 stated enhanced barrier precautions protected at risk residents from possible cross contamination from staff's clothing and hands. Any resident with chronic wounds or indwelling medical devices should be on enhanced barrier precautions. The open areas could become infected more easily. They were currently working on the policy for enhanced barrier precautions, and they did not realize it was supposed to be implemented as of April 1, 2024. The nurse that implemented the precautions was responsible to put up signage for the precautions and make sure that the care plan was updated. 10NYCRR 415.19(a)(2)