STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40803 44838 49448 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure residents were treated with respect and dignity in a manner and environment that promotes maintenance or enhancement of quality of life for 6 of 11 residents (Residents #19, #36, #59, #379, and 2 anonymous residents) reviewed. Specifically, - Activities aide #7 and licensed practical nurse #2 had a verbal confrontation in front of Resident #19 after they ran out of portable oxygen during a group activity; - Certified nurse aide #8 stood over Resident #36 while assisting them with eating; - Resident #59 exhibited continuous disruptive verbal behaviors in a common area with other residents and was not removed from the space timely as planned. Additionally, the resident was transported in their wheelchair facing backwards by certified nurse aide #9; - 2 anonymous residents stated during a group meeting that staff would tell them they could not leave their rooms because portable oxygen was not available; - Certified nurse aide #10 entered Resident #379's room, who was legally blind, without announcing themself or informing the resident of care being provided. Findings include: The facility policy Resident Rights revised 2/2020 documented all employees treated residents with kindness, respect, and dignity. Residents in the facility had a right to a dignified existence, privacy and confidentiality and equal access to quality care. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Behavior Management revised 5/2020 documented residents who exhibited behavior symptoms were taken aware to a quiet controlled space. This could be a utility room, or any area that served as a time out space and the resident was given time to calm down. 1) Resident #36 was admitted to the facility with diagnoses including dementia, Parkinson's disease (a progressive neurological disorder), and dysphagia (difficulty swallowing) The 3/30/2024 Minimum Data Set assessment dated documented the resident had severely impaired cognition, was dependent for eating, and received a mechanically altered diet. The comprehensive care plan initiated 10/23/2023 and revised 3/25/2024 documented the resident had an activities of daily living deficit related to limited mobility and was dependent on 1 for eating. During observations on 5/6/2024 at 11:33 AM and on 5/8/2024 at 8:51 AM Resident #36 was observed in their reclining chair in the hallway being fed by certified nurse aide #8 who stood while they were feeding the resident. During an interview on 5/10/2024 at 9:17 AM licensed practical nurse #6 stated staff should assist residents with meals while seated next to the resident and should not stand next to them. Staff should be at eye level with the resident so chewing and swallowing were visualized. They had seen certified nurse aides stand over Resident #36 during meals and this was not appropriate. During an interview on 5/10/2024 at 10:08 AM registered nurse Unit Manager #5 stated staff should be seated and interacting with residents while they assisted with feeding. It gave the resident a sense of comfort for staff to be at eye level during feeding. During an interview on 5/10/2024 at 10:44 AM certified nurse aide #8 stated they stood while feeding Resident #36 because it was more comfortable for them than sitting. 2) Resident #59 was admitted to the facility with diagnoses including Alzheimer's disease. The 4/30/2024 Minimum Data Set assessment dated documented the resident had severely impaired cognition, had daily behavioral symptoms not directed towards others, was dependent for most activities of daily living, and used a manual wheelchair. The comprehensive care plan initiated 8/18/2023 and revised 10/26/2023 documented the resident exhibited behavior symptoms. Interventions included determine the cause of behavior and remove the resident, distract with activities of interest, redirect negative behavior as needed, use 2 caregivers when the resident exhibited behaviors. Staff would intervene to attempt to calm the resident when they displayed escalating behaviors. Resident #59 was observed: - on 5/7/2024 during a continuous observation from 11:36 AM-12:14 PM, seated in their reclining wheelchair in the hallway outside of their room. There were other residents and families in the area. The resident continued with repetitive verbal behaviors. Certified nurse aide #9 was seated next to the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 5/7/2024 at 12:14 PM, seated in their reclining chair. Certified nurse aide #9 transported the resident from the hallway to the courtyard while the resident was facing backwards. - on 5/7/2024 during a continuous observation from 12:42 PM-1:22 PM, seated in their reclining wheelchair in the hallway outside of their room. The resident exhibited repetitive verbal behaviors with other residents and families present in close proximity. Certified nurse aide #11 was seated next to the resident. - on 5/8/2024 during a continuous observation from 10:09 AM-11:46 AM, seated in their reclining wheelchair in the hallway outside of their room, exhibiting repetitive verbal behaviors with other residents and families present in close proximity. Certified nurse aide #9 was seated next to the resident. - on 5/8/2024 at 11:46 AM, seated in their reclining chair. Certified nurse aide #9 transported the resident from the hallway to the courtyard while the resident was facing backwards. During an interview on 5/9/2024 at 1:31 PM certified nurse aide #9 stated they attempted to distract Resident #59 when behaviors were exhibited. It was common the resident yelled out in the hallway. It was not respectful the resident displayed continuous verbal behaviors in the hallway with an audience. The resident should have been moved to a quiet environment timelier. They stated they should not have transported the resident backwards because it was not dignified or respectful to the resident. They should have pushed the resident in front of them for safety reasons. During an interview on 5/10/2024 at 10:20 AM licensed practical nurse #6 stated they expected the certified nurse aides to remove residents from public areas when disruptive behaviors were displayed. Resident #59 often displayed verbal behaviors and it was disruptive to other residents and often caused other residents to escalate if they had behavioral symptoms. It was not respectful or dignified the resident was not moved from the public space timely. Residents should not be transported backwards, and it could increase the chance of a fall. During an interview on 5/10/2024 at 11:20 AM registered nurse Unit Manager #5 stated Resident #59 yelled out in the hallway frequently and should have 1 on 1 care but there was not enough staff. It was not dignified, or respectful to other residents and families who witnessed the behaviors. They were not sure if it was appropriate if the resident was transported backwards. During an interview on 5/10/2024 at 12:15 PM the Director of Nursing stated if Resident #59 was not easily calmed down they should be moved to another area. It was not dignified or respectful they were kept in the hallway while others witnessed the behaviors. Staff should push, not pull, residents in their wheelchairs for safety and dignity. 3) Resident #379 was admitted to the facility with diagnoses including legal blindness. The 5/1/2024 Minimum Data Set assessment documented the resident was cognitively intact, had severely impaired vision, required partial/ moderate assistance with eating and oral/personal hygiene, substantial/maximum assistance with toileting and bathing, and was dependent for transfers. The comprehensive care plan initiated 4/21/2023 and cancelled on 4/28/2023 documented the resident was legally blind in both eyes. Interventions included knock on the resident's door before entering and introduce yourself each time when entering their room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan initiated 4/26/2024 documented the resident had impaired visual function related to blindness. Interventions included room and personal items were arranged per resident preference and the resident was told where their items were placed. On 4/21/2023 During an observation on 5/6/2024 at 8:09 AM, certified nurse aide #10 entered the resident's room without knocking. The resident asked what their name was. Certified nurse aide #10 identified themselves and proceeded to reposition the resident in bed without explaining prior to touching and moving the resident in their bed. The bed was then lowered. Resident #379 stated they wanted to be told what was being done to them since they could not see. During an interview on 5/8/2024 at 11:46 AM licensed practical nurse #2 stated they expected staff to knock and introduce themselves before entering a resident's private space. It was especially important for Resident #379 because they had a visual impairment. It was not homelike if staff did not knock before entering a resident's room. During an interview on 5/9/2024 at 1:59 PM Corporate registered nurse #1 stated they expected staff to knock and introduce themselves before entering a resident's room. Residents should know who entered their room. 10NYCRR 415.(a)

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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 5/6/2024-5/10/2024, the facility did not ensure a resident's ability to safely self-administer medications was clinically appropriate for 1 of 1 resident (Resident #45) reviewed. Specifically, Resident #45 had lidocaine-prilocaine cream (topical cream used to numb skin before a medical procedure) at their bedside and there was no documented evidence the resident was assessed for their ability to safely self-administer the medication. Findings include: The facility policy Medication-Self Administration reviewed 7/2019 documented the 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, all medications would be administered by a nurse from the stored medication in the med cart. 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 #45 had diagnoses including end stage renal disease (kidney disease) and dependence on hemodialysis (a treatment that filters waste and water from the blood). The 4/16/2024 Minimum Data Set assessment documented the resident was cognitively intact, received hemodialysis, and required supervision/touching assistance with personal hygiene, oral hygiene, upper body dressing, and transfers. The comprehensive care plan initiated 4/11/2024 documented the resident required assistance with self-care and mobility related to impaired balance, limited mobility, and dialysis. Interventions included the resident was independent with personal hygiene. The comprehensive care plan initiated 4/11/2024 documented the resident needed hemodialysis related to end stage renal disease and nonadherence to prescribed fluid restrictions. Interventions included the resident received dialysis on Monday, Wednesday, and Friday; monitor left arm arteriovenous fistula (tube or device surgically implanted to create an artificial connection between an artery and a vein for dialysis access) for bruit (rumbling or whooshing sound heard with a stethoscope) and thrill (rumbling or buzzing sensation that is felt) every shift; monitor/document/report signs and symptoms of infection to access site; and check and change dressing daily at access site if ordered by the provider. There was no documented evidence the resident had a plan in place to self-administer medications including lidocaine-prilocaine cream. During an observation and interview on 5/6/2024 at 9:42 AM, Resident #45 was sitting in their room on the edge of their bed. There was a white tube of lidocaine-prilocaine 2.5% cream on their nightstand. The resident stated they applied the cream on their left upper arm access site (fistula) before dialysis on Monday, Wednesday, and Friday so the area was fully numb before the site was accessed. Facility staff was aware they applied the cream before dialysis and sometimes after if the access site was still sore. They stated they were unsure if they could keep the medication in their room, staff had not said anything about keeping it on their nightstand. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The May 2024 physician order listing report did not include an order for lidocaine-prilocaine 2.5% cream or instructions for self-administration of any prescribed medications. During observations on 5/8/2024 at 11:03 AM, and 5/9/2024 at 10:15 AM and 3:19 PM a white tube of lidocaine-prilocaine 2.5% cream was on the resident's nightstand in their room. There was no documented evidence that a medication self-administration assessment was completed for the resident. During an interview on 5/9/2024 at 1:53 PM, certified nurse aide #3 stated they were responsible for keeping resident rooms tidy so housekeeping could clean the room. If they found medication in a resident's room, they would notify the medication nurse. They did not notice any medication or creams in Resident #45's room, or they would have notified the nurse. During an interview on 5/9/2024 at 1:59 PM, licensed practical nurse #2 stated before a resident went to dialysis, they were responsible for obtaining vital signs and filling out the dialysis communication log. Sometimes dialysis centers would request the facility to put lidocaine cream on a resident's access site before they left for dialysis, but they had not requested it for Resident #45. They stated if the dialysis center had requested the cream, it would need a medical order. Resident #45 should not apply it themselves, and the nurse should keep the medication in the cart and apply it for them. Residents could only keep medications at their bedside if they had a physician order to self-administer medications, and Resident #45 did not have an order. They stated it was not safe for Resident #45 to keep the medication at their bedside because they could have used it incorrectly or another resident could take it. During an interview on 5/10/2024 at 10:31 AM, Regional Registered Nurse #1 stated residents could have medications in their room if they were evaluated and deemed safe for self-administration. A licensed nurse could evaluate the resident, but a physician order was required to keep medications at the bedside. Resident #45 did not have an order for self-administration so no medications should have been kept in their room. If staff saw medications in Resident #45's room, they should remove them and lock them in the medication cart for safe keeping so no residents had access to them. They were unsure how it happened because staff did rounds on the unit and would go through resident drawers to look at things. 10NYCRR 415.3(e)(1)(vi)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803 Based on observation, record review, and interview during the recertification and abbreviated (NY00312922 and NY00340114) surveys conducted 5/6/2024-5/10/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 2 (North and South units) resident units and the main dining room. Specifically, on the North unit resident rooms [ROOM NUMBERS] had used incontinence briefs on the floor and nightstand; resident 209 smelled of urine; resident room [ROOM NUMBER]'s door handle was broken; and resident rooms [ROOM NUMBER] had sliding glass door restrictors that were not maintained. On the South unit resident rooms [ROOM NUMBERS] light fixtures were missing covers, had open light sockets, and exposed wiring; and there was a broken table in the main dining room. Additionally, residents received cold beverages in disposable cups at meals. Findings include: The facility policy Resident Rights revised 2/2020 documented the residents had a right to a dignified existence. The facility policy Elopement-Prevention revised 3/13/2024 documented the physical plant should be secured to minimize the risk of elopement and may include but was not limited to the following: functional alarm system or magnetic locks with egress alarms for egress and stairwells, interior courtyards, safety locks or key-pad entry that restrict access to dangerous areas, securement and/or monitoring of the main entrance or lobby, and restricted window openings. Resident Rooms The following observations were made on the North unit: - on 5/6/2024 from 7:04 AM-9:52 AM, a used brief was laying on the floor next to an occupied bed in resident room [ROOM NUMBER]. - on 5/7/2024 at 8:32 AM, resident room [ROOM NUMBER] smelled of urine. - on 5/8/2024 at 12:14 PM, resident room [ROOM NUMBER]'s door handle had sharp metal edges and the door would not open. - on 5/9/2024 at 7:57 AM, a used brief was on the bedside table of room [ROOM NUMBER]. During an interview on 5/10/2024 at 9:02 AM certified nurse aide #15 stated after staff changed a resident's brief it should be placed in a bag and brought to the soiled utility room. Used briefs should not be left on the floor or on bed side tables. It was not dignified or homelike and could lead to odors in the room. Any staff that observed used briefs left in the room should remove them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/10/2024 at 9:10 AM licensed practical nurse #27 stated used briefs should be removed from the resident's room after care was provided. It was not dignified or homelike for used briefs to be left in a room. During an interview on 5/10/2024 at 10:17 AM Regional Registered Nurse #1 stated they expected staff to remove used briefs from resident rooms once care was provided. It was not dignified or homelike for the residents to have used briefs in their rooms. The following observations were made on the South unit: - on 5/7/2024 at 10:47 AM, resident room [ROOM NUMBER]'s light over the sink was missing the cover and the light did not turn on. - on 5/7/2024 at 10:50 AM, resident room [ROOM NUMBER]'s dome light over the sink and closet area were missing the covers, the lights did not work, and there were open sockets hanging by the wires a few inches below the light. - on 5/8/2024 at 12:10 PM, resident room [ROOM NUMBER]'s door handle to the sliding door was broken and the door would not open. - on 5/9/2024 at 12:20 PM, resident room [ROOM NUMBER] had tape on the window and sliding door. During an interview on 5/7/2024 at 10:47 AM Regional Director of Housekeeping and Laundry Services #23 stated lights should be covered and not exposed. During an interview on 5/9/2024 at 11:54 AM housekeeper #43 stated if they noticed broken equipment in a resident room or throughout the facility they would alert another staff member, but they would not fill out a work order form. They had not noticed any broken light fixtures or issues with door handles. During an interview on 5/10/2024 at 11:09 AM Regional Director of Housekeeping and Laundry Services #23 stated the tape on the window and sliding door in resident room [ROOM NUMBER] prevented a draft from the glass panels. A resident could not open the window if it was taped and would need staff assistance. The tape had been got 1-2 years. There was no documentation regarding the tape on the window and sliding glass door. Sliding Door Restrictors During an observation on 5/8/2024 at 11:51 AM, resident room [ROOM NUMBER] was equipped with a sliding glass door to the outside that functioned as the room's operable window. The door was tested by the Director of Housekeeping and Laundry and opened about 9 inches wide. They stated the door was equipped with a stopper which was intended to restrict the door opening to at most 6 inches, but the stopper had been moved. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/8/2024 at 11:53 AM, resident room [ROOM NUMBER]'s sliding glass door to the outside was tested by the Director of Housekeeping and Laundry and opened about 10 inches wide. The surveyor was able to fit their head and shoulders through the opening. The stopper was visibly moved beyond where the original hole was drilled in the window tract which was intended to restrict the width of the opening. During an observation on 5/8/2024 at 12:16 PM, the sliding door in room [ROOM NUMBER] was opened 12 inches and led to the yard that surrounded the facility. The surveyor could easily fit their head and shoulders through the door opening. During an observation on 5/8/2024 at 12:20 PM, the Regional Director of Housekeeping and Laundry moved the sliding glass door restrictor in room [ROOM NUMBER] and the door opened 6 inches. During an interview on 5/9/2024 at 1:53 PM, certified nurse aide #3 stated the staff opened the sliding glass doors in the resident rooms upon request because it was hard for the residents to open them. The lock was on the handle and each door had a restrictor on them, so they did not open all the way. They stated they had not heard or seen any resident's fit through the door opening and they thought they were only supposed to open a few inches. If the door opened too far, they would notify the nurse or the Administrator because a resident could get out without staff knowing. During an interview on 5/9/2024 at 2:11 PM, licensed practical nurse #2 stated the residents' sliding glass doors had restrictors so they would only open to a certain point. If a door opened further than the rest, they would shut the door and notify the Administrator or maintenance immediately so the resident could not get out or allow another person to get in the room. During an interview on 5/10/2024 at 12:09 PM, the Director of Housekeeping and Laundry, the Regional Director of Housekeeping and Laundry, the Regional Administrator, and the Administrator were present. The Director of Housekeeping and Laundry stated the sliding glass door to the outside was the window in the resident's rooms and those doors were supposed to be restricted to open no more than six inches. They stated the windows were supposed to be checked by the Director of Maintenance, who was unavailable during survey. The inspections were monthly and should have been documented. The Regional Administrator stated they were unable to find any documentation. The Director of Housekeeping and Laundry stated it was important to maintain the sliding doors at the appropriate width to prevent the residents from eloping. Dining The following observations were made during mealtimes: - on 5/6/2024 at 9:37 AM the North unit meal trays had cold beverages in plastic disposable cups. - on 5/8/24 at 12:51 PM the North unit had cold apple raspberry juice in plastic disposable cups. During an interview on 5/10/2024 at 10:56 AM the Food Service Director stated food and drinks should not be served using disposable dishes. Disposable dishes should only be used in an emergency. It was not homelike to receive food and drinks in disposable dishes and cups. This is something staff had been doing since they started a couple of months ago and the kitchen was short staffed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Broken Table During an observation on 5/6/2024 at 7:56 AM, there was 1 severely broken table in the corner of the main dining room by the fish tank. During an interview on 5/6/2024 at 7:56 AM the Director of Housekeeping stated staff did not remove the table after it was broken and pushed it into the corner of the dining room. During an observation on 5/9/2024 at 4:31 PM there was 1 severely broken table located in the corner of the main dining room by the fish tank. During an interview on 5/10/2024 at 12:09 PM the Administrator, the Director of Housekeeping, and Regional Director of Housekeeping and Laundry Services #23 stated if staff observed any broken items in resident rooms or throughout the facility a work order should be filled out. It was important to maintain a safe and clean environment to promote resident safety. 10 NYCRR 415.29(j)(1) 43754

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50561 Based on observation, record review, and interviews during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 1 of 1 of resident (Resident #72) reviewed. Specifically Resident #72 did not have resident-specific interventions for their language barrier or for their potential to become a victim of verbal or physical abuse. Findings include: The facility policy Translation Services last revised 1/2020, documented the facility's language access program would ensure that individuals with limited English proficiency shall have meaningful access to information and services provided by the facility. The facility policy Residents Rights last revised 2/2020, documented residents had the right to communication with and access to people and services, both inside and outside the facility The facility policy Behavior Management last revised 5/2020, documented the facility must provide an interdisciplinary approach for the care of residents who exhibit problem behavioral symptoms which could lead to negative consequences for themselves or others. The facility policy Activities of Daily Living Care and Support last revised 3/13/2024, documented care and support 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 resident's assessed needs, personal preferences, and individualized plan of care, that included but was not limited to supervision and assistance with hygiene, mobility, elimination, dining, and communication. Resident #72 had diagnoses including dementia and depression. The 3/12/2024 Minimum Data Set assessment documented the resident's preferred language was [not English] and they needed/wanted an interpreter. The 4/20/2024 Minimum Data Set, dated dated dated documented the resident was not interviewed to determine cognitive status and staff assessed the resident to have severely impaired decision making abilities, had unclear speech, was rarely/never understood, rarely/never understands, required substantial/maximum assistance for transfers, and ambulation was not attempted due to medical condition or safety concerns. The 3/12/2024 Admission Nursing Assessment completed by Registered Nurse Unit Manager #5 documented the resident was confused, did not speak English, an interpreter was required, spoke [a foreign language], and needed or wanted an interpreter to communicate with a doctor or health care staff. The comprehensive care plan initiated 3/13/2024 documented the resident required assistance with self-care and mobility. Interventions included the resident was to participate to the fullest extent possible with each interaction. There was documented evidence of a plan of care for the resident's language barrier. (continued on next page)

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Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/19/2024 speech therapy discharge summary did not document therapy or interventions regarding a language barrier. The comprehensive care plan problem initiated 4/22/2024 documented the resident exhibited behavioral symptoms such as agitation and restlessness. Interventions included acknowledging the resident's feeling and encouraging them to express their feelings. The 5/2/2024 Physician Assistant #13 progress note documented the resident had a weight loss and they were unable to assess their appetite as the resident did not speak English. The comprehensive care plan did not include a communication problem or potential for victimization. During an observation on 5/6/2024 at 7:34 AM, the resident was brought to the nursing station in their wheelchair. The resident repeatedly tried to get up unassisted and attempted to talk to licensed practical nurse #6 who replied, I don't know what you are saying honey. Sit down. Breakfast will be here soon then walked away. The resident continued to attempt to stand. At 8:32 AM, the resident remained at the nursing station attempting to stand from their wheelchair. Another resident repeatedly told the resident to sit down, and the resident continued to attempt to stand up. The same resident yelled harshly at Resident #72 to sit down. When Resident #72 did not sit down, the other resident yelled even louder and slammed their hand on a table in front of Resident #72 with enough force that it caused a loud crashing noise and the table to shake. There was no staff in the hall at the time of the incident and staff did not respond to the loud sound. The resident continued to attempt to get up and repeatedly looked up and down the hall. During an interview on 5/6/24 at 11:15 AM, Resident #60 (Resident #72's roommate) stated Resident #72 resident moaned and talked all the time, but no one could understand what they were trying to say. They stated the resident was very unstable on their feet and came over to their side of the room all the time. When they tried to tell the resident to return to the other side of the room Resident #72 did not always respond. Resident #60 recalled an incident when they had to yell, scream, and raise their fist at the resident to make them turn around. They denied any physical altercations with the resident. During an observation on 5/8/2024 at 1:25 PM the resident was in bed pulling at the closed privacy curtain between them and their roommate, Resident #60. The resident was calling out indiscernible words. Resident #60 was on the other side of the curtain watching television. Staff entered the room and Resident #72 was brought to the central area of unit. The resident was alert, fiddling with their shirt, and speaking unintelligible words. The comprehensive care plan initiated 5/9/2024 documented the resident's primary language was not English. Interventions included provide a communication tool in the resident's room and at the nursing station for staff to use, provide telephone translator service information at nursing station, speak slowly, and face the resident, and use gestures and visual cues as appropriate. During an observation on 5/9/2024 at 11:30 there was no picture or communication tools in the resident's room or at the nursing station. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 11:58 AM, certified nurse aide #11 stated if a resident needed any aids to help with communication it would be listed as a task for them to sign for. They believed the resident spoke English at one time. The resident had been combative during care delivery, and they used hand motions, gestures, and spoke in short sentences to try to better communicate with resident. They were unaware of any specific interventions for communication like a picture chart and had never seen one in the resident's room. During an observation on 5/10/2024 at 9:14 AM telephone translator service directions were not posted at the nursing station. Licensed practical nurse #6 stated they were unable to find the directions and thought it might be in the Nurse Manager's office. During an interview on 5/10/24 at 9:30 AM, certified occupational therapist assistant #26 stated they used gestures, a picture communication/picture board, and Google interpreter (a phone/computer application used to translate languages) to communicate with resident with some success. They had tried the language line but, because the resident was soft spoken, the interpreter was unable to hear the resident clearly. They thought the picture communication tool was kept on the resident's chair but could not find. They recalled an instance when the resident appeared frustrated and pointed to a mad emotion face on the picture chart to communicate this. They stated they were going to get the resident a new picture chart as they would feel better knowing the resident had one with him. During an interview on 5/10/2024 at 10:40 AM, licensed practical nurse #6 stated if a resident had a communication barrier identified on admission a picture/communication chart should be given to the resident and it would be reflected on the Kardex. They stated occupational therapy had the picture boards and anyone could ask for one as communication was everyone's responsibility. It was important to be able to communicate with residents or needs might not be met or even ignored. They did not see a picture/communication tool at the nursing station area but believed there was information pertaining to the language line on the bulletin board. They stated the resident has been frustrated a lot because of the communication barrier. The resident had lashed out, yelled, and kicked at staff. They could sometimes understand simple things the resident said and tried to speak simply and use gestures. They called for the assistance of a staff member that spoke the same language to help communicate with resident. They had not used a picture chart. They believed when the resident was on the rehabilitation unit, they had a picture/communication chart, but it did not come with the resident when they were transferred the current unit. During an interview on 5/10/2024 at 11:36 AM, Registered Nurse Manager #5 stated if a resident had a communication barrier identified on admission there should be a care plan developed by the Nurse Manager. Interventions could include using an interpreter phone and asking family to interpret. They did not know if the resident was care planned for a language barrier or if there were any person specific interventions. I was important barriers were identified so the resident could communicate their needs. They were aware the resident has been frustrated at times and has been aggressive towards staff and the resident's roommate did not like the resident because they made a lot of noise. They were not aware of any physical altercations between the resident and their roommate but thought there was a risk for this to happen. They also felt there was a risk for the resident to be yelled at by the roommate. They did not know if the resident was care planned to be at risk to be a victim or if there were any specific interventions to keep the resident safe. They stated that all residents in the nursing home had a potential to be a victim and should be care planned for this. 10NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 40803 44838 48675 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00212922, NY00310702, and NY00310431) surveys conducted 5/6/2024-5/10/2024, 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 4 of 10 residents (Resident #1, #12, #35, and #37) reviewed. Specifically, Resident #1 was not assisted with dressing; Resident #12 was not assisted with bathing; Resident #35 was not assisted out of bed or supervised with meals; Resident #37 had unclean and untrimmed fingernails. Findings include: The facility policy Activities of Daily Living Care and Support revised 3/13/2024 documented residents received activities of daily living care and support in accordance with current standards of practice based on the resident's assessed needs, personal preferences, and goals of care. Care and support were provided to residents who were unable to carry out activities of daily living independently and included hygiene (bathing, dressing, grooming, and oral care), mobility, toileting, transfers, dining, and communication. The resident's bath or shower was scheduled per resident preference and was completed at a minimum of weekly. Nail care was provided as needed. The amount of assistance provided to the resident was documented in the clinical record. 1) Resident #1 was admitted to the facility with diagnoses including dementia, major depressive disorder, and glaucoma (progressive loss of vision). The 3/1/2024 Minimum Data Set assessment dated documented the resident had severely impaired cognition, required supervision for upper body dressing, and partial/ moderate assistance for lower body dressing, and did not reject care. The comprehensive care plan initiated on 10/26/2021 and revised 10/6/2023 documented the resident had an activity of daily living deficit related to dementia. Interventions included supervision, verbal cues or touching assistance of 1 for upper body dressing, and partial assistance of 1 for lower body dressing. The undated care instructions (Kardex) documented the resident received a shower/ bath on Tuesday and Friday on the day shift, received morning and evening personal hygiene care, and required assistance for dressing. Resident #1 was observed at the following times: - on 5/7/2024 at 12:19 PM sleeping in bed wearing a black nightgown with pink flowers; at 12:54 PM sitting up on the side of the bed wearing a black nightgown with pink flowers; and at 2:35 PM sleeping in bed wearing a black nightgown with pink flowers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 5/8/2024 at 8:55 AM sleeping in bed wearing a black nightgown with pink flowers; at 10:01 AM in the hallway asking for water wearing a black nightgown with pink flowers; at 12:02 PM sleeping in bed wearing a black nightgown with pink flowers; at 1:19 PM sitting on the side of the bed eating lunch wearing a black nightgown with pink flowers; and at 2:43 PM sleeping in bed wearing a black nightgown with pink flowers. - on 5/9/2024 at 9:11 AM sleeping in bed wearing a black nightgown with pink flowers; and at 9:24 AM walking out into the hallway asking for water wearing a black nightgown with pink flowers. The May 2024 certified nurse aide documentation for Resident #1 included: - on 5/7/2024 a bath was provided by certified nurse aide #11 at 10:00 AM. - on 5/7/2024 care was provided per Kardex by certified nurse aide #11 at 10:00 AM and at 8:19 PM. - on 5/8/2024 care was provided per Kardex by certified nurse aide #20 at 1:59 PM and by certified nurse aide #21 at 5:41 PM. - On 5/9/2024 care was provided per Kardex by certified nurse aide #20 at 11:59 AM and by certified nurse aide #9 at 3:08 PM. During an interview on 5/9/2024 at 12:43 PM certified nurse aide #11stated they gave Resident #1 a bath on 5/7/2024. They always took the resident to the shower room, and they assisted with bathing the entire body and then placed on a black nightgown with pink flowers. The resident was supposed to receive new clothing every morning or when soiled. This was charted electronically in the certified nurse aide documentation. The resident required assistance with bathing and dressing because they had poor vision. They stated certified nurse aide #20 was assigned Resident #1 today, but the resident was wearing the same nightgown they assisted with putting on after the shower a couple of days ago. During an interview on 5/9/2024 at 1:18 PM certified nurse aide #20 stated they were expected to follow the Kardex and document tasks if they were completed. If a resident refused, it was documented as a refusal. They stated the residents only got clean clothing on shower days, but they should get clean clothing every day. They were assigned Resident #1 but had not been in their room at all today because they were too busy. They were also assigned the resident yesterday and did not assist them with dressing. During an interview on 5/10/2024 at 10:10 AM licensed practical nurse #6 stated residents got clean clothes twice daily, once in the morning and once at night, or more if soiled. This was important for good hygiene and residents should get the care they needed and should feel clean. They expected all residents to be clean and dressed daily. During an interview on 5/10/2024 at 11:20 AM registered nurse Unit Manager #5 stated certified nurse aides were expected to change residents clothing daily and if it was documented, it meant it was completed. It was not appropriate for Resident #1 to be in the same nightgown for 3 days. It was not proper hygiene and put the resident at risk for infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #12 had diagnoses including major depressive disorder, anxiety disorder, and chronic obstructive pulmonary disease (restrictive lung disease). The 4/28/2024 Minimum Data Set assessment documented the resident was cognitively intact, required substantial/ maximum assistance with bathing, and did not reject care. The comprehensive care plan initiated on 4/23/2024 documented the resident preferred a sponge bath. Interventions included assistance with daily routine as needed. The resident required assistance with self-care related to impaired balance and limited mobility. Interventions included shower/ bath on Tuesday and Friday evening shift. The undated care instructions (Kardex) documented the resident required substantial/ maximum assistance of 1 for bathing and the helper completed more than half of the activity. The May 2024 certified nurse aide documentation included a shower/ bath was completed by certified nurse aide #3 at the following times: - On 4/23/2024 at 9:06 PM - On 4/26/2024 at 9:59 PM - On 4/30/2024 at 8:28 PM - On 5/3/2024 at 9:20 PM. During an interview on 5/6/2024 at 11:20 AM Resident #12 they stated they had been at the facility for 3 weeks and had not been offered or received a shower until today. Certified nurse aide #3 had told them they could have a shower tomorrow. The May 2024 certified nurse aide documentation included a shower/ bath was completed by certified nurse aide #3 on 5/7/2024 at 9:02 PM. During a follow up observation and interview on 5/9/2024 at 11:47 AM, certified nurse aide #3 exited the resident's room with a bag of dirty linens. Resident #12 was lying in their bed wearing a clean hospital gown and stated they just got cleaned up in bed by the certified nurse aide. They stated they asked when their next shower day was, and the certified nurse aide stated they would let them know. They would like to get their showers in the morning and now that they received their first shower a couple of days ago (5/7/2024), they wanted to receive them regularly as they felt much better afterwards. During an interview on 5/9/2024 at 1:46 PM certified nurse aide #3 stated the Kardex provided the level of assistance needed and listed shower days. They had given Resident #12 a shower on 5/7/2024 and it was their first shower since admission. They did not think the resident had been there that long. The resident did not refuse care. They thought they had given bed baths on the other documented days, and they did not always have time to give showers as planned. Showers were important for hygiene and dignity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2024 at 2:21 PM licensed practical nurse #2 stated certified nurse aides were expected to reference the Kardex for shower days and showers should be given as scheduled. They were not notified of any refusals by the resident. It was dignified to receive showers and the residents felt better and deserved good hygiene. During an interview on 5/10/2024 at 10:26 AM registered nurse #1 stated the Kardex was where information regarding shower days was located. They stated showers should always be offered and if a resident refused a bed bath should be offered. It was not acceptable the resident had been offered one shower since admission as residents were scheduled for showers twice a week. All residents deserved showers for proper hygiene. 3) Resident #35 had diagnoses including protein-calorie malnutrition, major depressive disorder, and normal pressure hydrocephalus (a brain disorder). The 3/1/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, required supervision with eating, was dependent with toileting, dressing, bathing, and transfers, and did not reject care. The comprehensive care plan initiated 12/30/2022 and revised 11/29/2023 documented the resident required assistance of 2 with a mechanical lift for transfers, and required supervision, verbal cues or touching assistance of 1 for eating. The May 2024 Documentation Survey Report for activities of daily living documented care was provided per the Kardex on all shifts from 5/6/2024-5/9/2024. Resident #35 was observed at the following times: - on 5/6/2024 at 7:00 AM and at 8:46 AM lying in bed in a hospital gown - on 5/7/2024 at 9:05 AM sitting up in bed eating breakfast in a hospital gown, no staff was present in the room supervising the resident. - on 5/7/2024 at 12:02 PM lying in bed in a hospital gown. - on 5/7/2024 at 12:52 PM, sitting up in bed in a hospital gown eating lunch, no staff was present in the room to supervise the resident's lunch meal. - on 5/8/2024 at 8:51 AM sitting up in bed in a hospital gown with their breakfast on the overbed table, there was no staff present in the room to supervise the resident's meal. - On 5/8/2024 at 9:07 AM sitting up in bed in a hospital gown with breakfast tray untouched. At 9:12 AM, an unidentified certified nurse aide walked into the room and asked why they were not eating and then exited the room without providing assistance. The 5/8/2024 at 8:28 AM percentage of meals eaten documented the resident consumed 51-75% of the morning meal and 166-239 cubic centimeters of fluid. There were no documented staff name to accompany the percentages. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2024 at 10:24 AM certified nurse aide #11 stated the level of care residents required was in the care plan. They were responsible for getting residents out of bed daily. They stated Resident #35 required supervision and verbal cues with meals and they should not have eaten alone in their room. They were not sure if they had offered to get the resident out of bed, but all residents should be offered to get up every day. During an interview on 5/10/2024 at 9:00AM licensed practical nurse #6 stated the level of care assistance residents needed was located on the care plan and included transfers, meals, and personal care. Resident #35 required supervision with meals and should not have been left alone. If the resident did not eat, the certified nurse aides should provide encouragement. The resident had eaten alone in their room this week and should not have. It was their responsibility to ensure the certified nurse aides completed the tasks as outlined in the care plan. They expected residents to get up and out of bed daily and if they refused, they should be notified, and the resident should be reapproached. During an interview on 5/10/2024 at 9:53 AM registered nurse Unit Manager #5 stated it was important that residents got out of bed to prevent pneumonia, bed sores, and it provided socialization. They stated one of the certified nurse aides informed them on 5/8/2024 that Resident #35 refused to get out of bed and the resident was not reapproached by them but should have been. The resident was also supposed to be supervised for meals and it was not appropriate they ate in their room alone. The resident needed varying levels of assistance with eating. During an interview on 5/10/2024 at 10:32 AM certified nurse aide #8 stated it was important for residents to get out of bed as it prevented decline. Resident #35 sometimes refused to get out of bed, and they would tell the nurse. They stated some days the resident could feed themselves and other days they could not. Because the resident required supervision with meals, they should not have been left alone in their room. 10NYCRR 415.12(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 44838 50561 Based on observation, record review, and interviews during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure ongoing provision of programs to support each resident in their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 of 2 residents (Residents #13 and #36) reviewed. Specifically, Residents #13 and #36 were not offered meaningful activities of their choosing as care planned. The facility policy Recreational Services last reviewed 5/2019 documented the facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. 1) Resident #13 was had diagnoses including depression and left lower leg amputation. The 8/17/2023 Minimum Data Set assessment documented the resident had moderately impaired cognition, mood symptoms were present 7-11 of 14 days, required assistance of 2 staff for transfers, was non-ambulatory, and felt that listening to music, pets, group activities, current events, and going outside were very important. The 8/16/2023 comprehensive care plan documented Resident #13 was able to make recreation and leisure preferences known. Their interests included music, Bingo, cards, animals, watching television and word searches. Interventions included provide the resident with independent leisure supplies and assist the resident to find programs of interest. The 11/1/2023-5/31/2024 Multi-Month Participation Report documented Resident #13 had two 15-minute one to one social visits for a total of 30 minutes. The 3/26/2024 Recreation Assessment and Documentation completed by Activities Director #29 documented Resident #13 preferred independent pursuits in their own room and current participation included puzzles and reading. The remainder of assessment was blank. The 5/9/2024 recreational calendar documented pet therapy was scheduled at 10:30 AM. During an observation on 5/9/2024 at 10:59 AM, Resident #13 was not in attendance at the pet therapy activity. During interviews on 5/6/2024 at 10:33 am, 5/9/2024 at 9:26 AM, and 5/9/2024 at 10:24 AM, Resident #13 stated they would like to go to activities but stayed in bed because the chair caused them back discomfort. They stated they did not receive any specific activities in their room, did not attend pet or music groups, and had not been outside since their admission. They were interested in pet therapy and mocktails that was on the 5/9/2024 activity schedule. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 2:04 PM certified nurse aide #30 stated Resident #13 had voiced interest in getting up for activities, but when it came time to get up, Resident #13 would refuse to do so. The only activity they witnessed Resident #13 do was watching television. They had not witnessed any in room activities being provided. During an interview on 5/9/2024 at 2:45 PM Activities Director #29 stated on admission they visited residents to determine their preferences. Those preferences were entered in the initial assessment and care plan. A daily chronicle, that included that day's activity schedule, was dispersed to each resident daily. The chronicle was reviewed with the resident by activities staff when they passed the chronicle out. They would ask the resident which activities they wanted to attend and would alert staff so the resident would be ready on time. If a resident could not or would not get up for an activity, they would bring items based on individual preferences and do a one to one activity in the room. They saw Resident #13 every day when they delivered the chronicle. Resident #13 was always watching television and often refused to get out of bed. They were unsure if Resident #13 was invited to the pet group that morning. There was no specific preference based activities provided to the resident. They felt one to one room visits, which should be done three times a week, were strongly lacking. After they reviewed the activity log, they stated only 1 one to one room visit with Resident #13 occurred since 8/10/2023. During an interview on 5/10/2024 at 10:40 AM licensed practical nurse #6 stated it was important that residents get up for activities and they expected if a resident declined, they would be informed. They stated Resident #13 should get up but often refused to do so or wanted to go back to bed almost immediately after they got up. They stated Resident #13 did not attend group activities, liked to watch television, and did not read the chronicle that was delivered daily. They had not observed any in room activities for the resident. During an interview on 5/10/2024 at 11:36 AM registered nurse Manager #5 stated their expectation was every resident got up and if not, it was reported to them. They documented refusals but was unsure if it should be care planned. They stated Resident #13 often refused to get out of bed. They had talked to the resident about this but was never given a reason for the refusals. There were no specific interventions to address the refusals and they did not know if Resident #13 was or should be care planned for refusals. They stated Resident #13 did not attend activities but thought a dog had been brought to them. 2) Resident #36 had diagnoses including metabolic encephalopathy (a chemical imbalance in the brain) and dementia. The 3/30/2024 Minimum Data Set assessment documented the resident had severely impaired cognition and was totally dependent for activities of daily living. The 10/24/2023 Minimum Data Set admission assessment documented the resident was interviewed for preferences for activities. The resident felt it was very important to listen to music, to be around animals, to do favorite activities, and to go outside to get fresh air when the weather was good; and felt it was somewhat important to keep up with the news and do things with groups. On 11/3/2023 Activities Director #29 documented in comprehensive care plan that resident was able to make recreation and leisure preferences known and interests included word searches, crosswords, animals, and music. Interventions included to invite and escort the resident to activities of choice/interest and provide independent leisure supplies. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/20/2024 Recreation Assessment and Documentation form completed by Activities Director #29 documented Resident #36 preferred independent pursuits in their room or on the unit, current participation included family visits, and participation type was independent. The remainder of assessment was blank. Resident #36 was observed at the following times: - on 5/6/2024 at 8:53 AM sitting in their chair in the hall outside of their room. At 11:32 AM sitting in the hall outside of their room in the same position as the earlier observation. - on 5/8/2024 continuously from 8:55 AM until 12:15 PM sitting in the hall outside their room. No staff interaction was observed, and no activities were offered or provided. - on 5/9/2024 at 9:52 AM sitting in their chair outside their room in the hall. During an interview on 5/10/2024 at 8:35 AM, Activities Director #29 stated activities provided daily socialization and activities. Activity care plans were based on resident preferences that were assessed on admission. If a family was interviewed regarding preferences, it would be reflected in the care plan. They provided a chronicle containing a puzzle and coloring activity to residents daily. Resident #36 would require assistance to complete the word search or coloring activity. At that time residents were asked what activities they would like to attend. If a resident had music listed as a preference, and they had a musical activity occurring, they would include that resident even if they were unable to respond. They stated Resident #36 typically sat in the hall. The resident's spouse visited daily and occasionally brought the resident to entertainment. The resident did not attend the music on 5/6/2024 and was not offered the option to attend. They stated Resident #36's care planned interests were animals, word searches, and crosswords and current abilities and interests should be reflected. The care plan did not document that a family interview was conducted, but they believed they talked to the resident's spouse. There were no one to one visits with Resident #36. They were lacking on those visits. The activity attendance log was marked for 5 minutes a day for 30 days for time spent delivering and reviewing the daily chronicle with Resident #36, but they were probably only in the room for a minute. 10NYCRR 415.5(f)(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49448 50561 Based on observation, record review, and interview during the recertification and abbreviated (NY00340114, NY00310431, NY00336364, and NY00310702) surveys the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 1 resident (Resident #60) reviewed. Specifically, Resident #60 had a recommendation for a follow up appointment with nephrology (kidney specialist) and there was no documented evidence the follow-up appointment was scheduled or occurred. Findings include: The facility policy Residents Rights last revised 2/2020 documented residents had the right to communication with and access to people and services, both inside and outside the facility. Resident #60 was admitted to the facility with a diagnose including chronic kidney disease, and acute kidney failure. The 2/22/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition and required partial to moderate assistance with transferring and ambulation. The 8/24/2023 hospital discharge summary documented the resident was hospitalized from 7/21/2023-8/24/2023 and was found to have bilateral (both sides) occlusion (blockage) of their renal arteries as well as severe acute kidney injury. The resident likely had chronic kidney disease stage 5 (end stage kidney failure) and would need close nephrology follow up within 1 week of discharge. The 8/25/2023 physician admission orders did not include a nephrology consult. The comprehensive care plan initiated 8/28/2023 documented the resident had impaired renal function related to chronic kidney disease. Interventions included referral to nephrology. Physician assistant #12 documented: - on 8/28/2023 an initial visit progress note. The resident had chronic kidney disease stage 5 and required a follow-up with nephrology in 1 week. Follow-up as directed in hospital discharge summary. - on 8/29/2023 and 9/1/2023 diagnosis and assessment included chronic kidney disease, required follow-up with nephrology. An order summary report documented a 9/1/2023 order to follow to follow up with nephrology. Physician assistant #12 documented: - on 9/8/2023, 9/25/2023, 9/29/2023, and 10/2/2023 diagnosis and assessment included chronic kidney disease, required follow-up with nephrology. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 10/10/2023 seen for an interval visit for review of medications and management of chronic disease. The resident wished to have their diet liberalized however, still did not have a nephrology consult. - on 10/30/2023 resident requested to be taken off renal diet. The resident still required follow-up with nephrology given chronic kidney disease and recommendations to follow up with nephrology initially upon admission. Interdisciplinary Team meeting note documented: - on 11/3/2023 plan to continue to attempt to secure a renal consult that week to assess liberalization of restricted diet. - on 11/10/2023 the resident was a high risk for weight loss, on a renal diet, and the resident wanted their diet liberalized but required a nephrology consult first. Physician assistant #12 documented: - on 12/21/2023, 1/22/2024, and 2/23/2024 diagnosis and assessment included chronic kidney disease, required follow-up with nephrology. - on 3/22/2024 interval visit had not followed up with nephrology yet. Stable required follow-up with nephrology. The Consultation Tracker for Resident #60, documented the following comments and did not include dates: - attempted to schedule with [local nephrology group]-unwilling to accept as a new patient as already established in [another city]. - attempted to get an appointment with nephrology in [another city]-office would not schedule appointment. - attempted to get appointment with [a second local nephrology group] who reported it was clinically not necessary. There was no documented evidence the medical provider was informed of the failed attempts for a nephrology consult. During an interview on 5/6/2024 at 11:15 AM and 5/7/2024 at 9:15 AM, Resident #60 stated they were supposed to see a kidney doctor and had been waiting since August and it had never happened. They stated they were on a special diet and did not like it. They were upset over their breakfast because they wished they had bacon or sausage, but their diet did not allow it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/10/2024 at 11:36 AM registered nurse Unit Manager #5 stated when a resident was admitted they would read through the discharge summary and orders. If there was a recommendation for a consult, they would enter an order for it for the physician to review and approve. They would personally notify the scheduler who would then schedule the appointment and update the order with the specific appointment details. They believed appointment information was entered into a spread sheet and they did not know the process for monitoring the spreadsheet to ensure appointments were followed up on. They did not routinely read the medical provider notes. They were aware Resident #60 needed a nephrology consult. During an interview on 5/10/2024 at 1:17 PM, physician assistant #12 stated when there was a new admission, nursing would review the discharge summary with them for approval. They expected what was being reviewed with them was accurate. If they wanted to order a consultation, they would write a note in the provider communication book and the nurse would enter the order which they would cosign. Once a consult had occurred, a copy of the consult form with the visit summary was left in the provider communication book for them to review. They expected their orders to be followed and notified if the orders were not followed. They did not have a process to follow up on consultations they ordered. They were aware Resident #60, did have a nephrology consult. Given a prior diagnosis of stage 5 renal failure, the resident should be seen by nephrology. Even a telemedicine appointment (appointment via phone call or video chat) would be acceptable. They were aware that the resident wanted to have a diet change and they felt a nephrologist should be the one to make that decision. During an interview on 5/10/2024 at12:25 PM, the Director of Nursing stated if a consult was recommended on a discharge summary the medical provider would review it. If they agreed, the appointment would be scheduled, and the information would be placed in a tracker. The consult tracker had been in place for the past three months and they had been conducting performance improvement audits on the tracker as they had received similar deficiencies in the past. They stated Nurse Managers had access to the tracker. They expected Nurse Managers to review provider notes and they reviewed them as well. They were aware the resident needed a nephrology consult and several places had been approached but would not see the resident because the resident did not have a need. The resident was in the process of transitioning to another group of providers and was hopeful once that happened the new providers would be able to facilitate the nephrology appointment. They stated if a resident did not attend the recommended appointments there could be a break in the continuation of care and a decline in medical status. 10 NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803 48675 Based on observation, record review, and interview during the recertification and abbreviated (NY00312922 and NY00314056) surveys conducted 5/6/2024-5/10/2024 the facility did not ensure each resident received adequate supervision and the environment remained as free of accident hazards as possible for 2 of 9 residents (Residents #42 and #379) reviewed. Specifically, Resident #379's bed was not maintained in the low position and their call bell was not in reach and Resident #42 was observed wandering, unsupervised, into other resident rooms without interventions in place for monitoring; Findings include: The facility policy Falls Management and Prevention revised 11/2019 documented the interdisciplinary team would identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. The staff would implement goals and interventions with resident/ family for inclusion in the interdisciplinary care plan based on the resident's individual needs. The facility policy Behavior Management revised 5/2020 documented the facility provided an interdisciplinary approach for care of residents who exhibited problem behavioral symptoms which could lead to negative consequences for themselves or others. Residents should be evaluated that appropriate interventions were instituted in a timely manner. Approaches included (but not limited to), increased supervision. Behavioral symptoms and approaches were placed in the resident specific plan of care. 1) Resident #379 had diagnosis including legal blindness. The 5/1/2024 Minimum Data Set Assessment documented the resident had intact cognition, had severely impaired vision, did not reject care, required partial/moderate assistance rolling left to right, was dependent for transfers from sitting to standing and chair to bed transfers, and had 1 fall with injury since admission. The 4/25/2024 Admission/Readmission Evaluation completed by the Director of Nursing documented the resident had 1-2 falls in the past six months, had severely impaired vision, and was totally incontinent of bladder and bowel. The resident was unable to independently come to a standing position and used assistive devices such as a cane or walker. Interventions included occupational therapy evaluation, physical therapy evaluation, and nonskid socks. The 4/26/2024 comprehensive care plan documented the resident had impaired visual function related to blindness. Interventions included to arrange room/personal items per resident preference and tell the resident where their items were placed. The resident required assistance with self-care related to confusion and limited mobility. Interventions included encourage the resident to use the call bell for assistance. The resident was at risk for falls/ had an actual fall. Interventions included to anticipate and meet the resident needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/27/2024 Initial Event Documentation completed by the Director of Nursing documented the resident had a fall at 8:51 AM on 4/27/2024 while attempting to self-transfer out of bed. The resident was lying on the floor on the left side of the bed. The resident had no apparent injuries but did complain of 10/10 pain to their low back and neck. The resident reported hitting their head on the floor. Neurological checks were at baseline. The resident refused to move their upper and lower extremities and an order was obtained to send the resident to emergency room for evaluation. A 4/27/2024 licensed practical nurse #27 progress note documented a fall risk evaluation was completed and the resident was at moderate risk for falls. A 4/27/2024 registered nurse #28 progress note documented the resident returned from the emergency department for a fall. The resident was alert and orientated. A 4/29/2024 Director of Nursing progress note documented the resident had a fall out of bed on 4/27/24 without injury. The resident was sent to emergency room for evaluation of pain and returned. The resident's care plans were reviewed, and it was determined it was appropriate to initiate a low bed to prevent recurrence. On 4/29/2024 the comprehensive fall care plan interventions were updated to include bed in low position. The undated care instructions (Kardex) documented the resident's bed was to be in the lowest position. During an observation on 5/6/2024 at 7:57 AM, the resident was in bed. The bed was at hip height with two fall mats on each side of the bed. The resident was lying on their left side with their knees hanging over the edge of the bed approximately 4- 6 inches. At 8:04 AM, the resident stated they felt like they were going to fall. They were holding onto the edge of the bed. Their call bell was activated. At 8:09 AM, certified nurse aide #10 entered the resident's room, without knocking and did not introduce themselves. They positioned the resident toward the center of the bed without telling them what they were doing. They then lowered the bed to the floor and exited the room. During an observation on 5/8/2024 at 8:41 AM, the resident was lying in bed. The bed was positioned at mid-thigh height and their call bell was on the floor. During an interview on 5/8/2024 at 9:26 AM certified nurse aide #3 stated Resident #379 was not on their assignment, but they provided the resident their meal tray. They did not notice if the resident's bed was in a low position and did not observe their call bell on the floor. They thought the resident had a vision impairment and was unsure if the resident was a fall risk. During an interview on 5/8/2024 at 9:32 AM certified nurse aide #10 stated Resident #379 was on their assignment. The care instructions listed in the computer alerted staff to any safety precautions needed, such as a low bed and fall mats. They dressed the resident that morning but did not observe their call bell on the floor. Their bed was not in a low position, and they had to lower it just as they had to do on 5/6/2024. They thought the resident had a recent fall but was unsure. They did not always check to ensure the bed was in a low position. The resident liked to lie on their side close to the edge of the bed and if the bed was in the high position, it could be a safety issue. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 4:40 PM Regional Registered Nurse #1 stated they expected staff to follow the care plans for safety reasons. If a resident had a history of falls staff should follow the fall care plan to ensure the resident was safe otherwise it posed a safety risk. Resident #379 was care planned for a low bed. The resident was visually impaired, so it was important their call bell was in reach. 2) Resident #42 had diagnoses including dementia and glaucoma (eye disease causing vision loss). The 3/29/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision or touching assistance for ambulation, used a wheelchair, and was able to wheel themself with supervision or touching assistance. The comprehensive care plan initiated 8/11/2021 and revised 4/30/2024 did not include risk for wandering or risk for victimization. The undated care instructions (Kardex) documented the resident used a 2 wheeled walker, used a wheelchair, and required set up for wheeling in their wheelchair (resident needed no help during the activity). The instructions did not include wandering risk or use of a wander alert device. The 3/29/2024 quarterly elopement evaluation completed by the Director of Nursing documented the resident was dependent for mobility and therefore was a low risk for elopement. Resident #42 was observed at the following times: - on 5/6/2024 at 7:27 AM and at 7:35 AM, self-propelling in their wheelchair down the South unit hallway. - on 5/6/2024 at 8:34 AM in their wheelchair self-propelling into room [ROOM NUMBER]. - on 5/6/2024 at 9:23 AM in their wheelchair self-propelling into room [ROOM NUMBER]. Resident #65 was in the hallway and stated the resident had once gotten in their bed while they were sleeping. Resident #65 was yelling in the hallway that they wanted Resident #42 out of their room. At 9:29 AM, the resident self-propelled in their wheelchair back out into the hallway. - on 5/8/2024 at 11:14 AM and at 12:09 PM self-propelling in their wheelchair down the south unit hallway. During an interview on 5/9/2024 at 2:05 PM certified nurse aide #9 stated residents who wandered had a wander alert device. They stated Resident #42 had a wander alert device and this information was found on the Kardex. They had seen the resident in Resident #65's and Resident #280's bed. The resident should not be in other residents' rooms or beds for safety reasons. They could get sick if they went into a room with precautions. The resident was also found in other resident beds on the North Unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/10/2024 at 10:10 AM licensed practical nurse #6 stated certified nurse aides would know if a resident was a wandering risk by referencing the Kardex. If they were a wander or elopement risk, they would have a wander alert device, and this was checked and documented on the Treatment Administration Record by the licensed practical nurse. Resident #42 wandered on the unit into other residents' rooms and beds but did not leave the unit. They did not know of any wandering interventions for the resident, but they should have interventions. The resident was at risk for victimization and could get hurt either verbally, physically, or could even be mistaken for another resident in their bed and receive the wrong medications. They should be monitored for their safety and the safety of other residents. The registered nurse Unit Manager was responsible for completing the wandering and elopement assessments. During an interview on 5/10/2024 at 11:20 AM Registered Nurse Unit Manager #5 stated wandering was included in the care plan as well as behaviors or elopement. They and the Director of Nursing were responsible for updating care plans. Staff should know if a resident wandered to prevent injury. They were aware Resident #42 wandered into other resident's rooms. The resident was at risk for victimization because another resident could get upset if they were in their room. Appropriate monitoring of the resident should have been included in the care plan. During an interview on 5/10/2024 at 12:15 PM the Director of Nursing stated wandering and victimization were included on the care plan for safety to ensure that the resident's needs were met. They knew Resident #42 wandered and was at risk for victimization because they could make another resident verbally or physically upset. Registered Nurse Unit Manager #5 was responsible for updating care plans. 10 NYCRR 415.12(h)(2) 49448 .

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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. 40803 Based on observation, interview, and record review during the recertification and abbreviated (NY00312922) surveys conducted 5/6/2024-5/10/2024, the facility did not ensure residents maintained acceptable parameters of nutritional status for 1 of 5 residents (Resident #75) reviewed. Specifically, Resident #75 was not weighed as ordered, did not received fortified pudding, and was not assisted with meals as care planned. Findings include: The facility policy Nutrition Assessment revised 8/2020 documented the nutritional assessment would be a systematic, multidisciplinary process that included gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Once current conditions and risk factors for impaired nutrition were assessed and analyzed, individual care plans would be developed that addressed or minimized to the extent possible the resident's risks for nutritional complications. Such interventions would be developed within the context of the resident's prognosis and personal preferences. The facility policy Weight Management revised 2/2023 documented the resident's weight would be obtained within 24 hours of admission, weekly for 4 weeks, then monthly thereafter and more frequently, as clinically indicated for the resident and documented in the clinical record. The facility policy Meal Service revised 4/2022 documented staff would check the individual name and diet on the meal identification card/ ticket to verify that the meal was served to the correct person, and check items on the plate/ tray to assure accuracy for therapeutic diets or texture or consistency modifications. Resident #75 had diagnosis including unspecified severe protein-calorie malnutrition, dysphagia (difficulty swallowing), and gastrostomy status (artificial opening to stomach for feeding tube). The 4/24/2024 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, was dependent for eating, weighed 109 pounds, had no significant weight changes in the past 30 to 180 days, received a mechanically altered diet, had a feeding tube, received 51% or more of total calories through parenteral or tube feeding, and 501 or more cubic centimeters of fluid daily by tube feeding. The resident received 150 minutes of speech-language pathology and audiology services and 180 minutes of occupational therapy during the 7-day period. The 4/18/2024 Nursing Admission Evaluation signed by the Director of Nursing documented the resident weighed 109.2 pounds and had lower extremity trace edema. The 4/19/2024 physician orders documented: - The resident was to receive enteral feedings via percutaneous endoscopic gastrostomy (feeding tube) of Jevity 1.5 (tube feeding formula) at 50 milliliters starting at 5:00 PM for a total volume of 1000 milliliters. Administer 100 milliliters of water 4 times daily before and after each tube feeding administration. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- weigh on Admission/Readmission once, then weekly for 4 weeks, and then monthly. Weight must be obtained by the 7th of the month. The comprehensive care plan initiated on 4/19/2024 documented the resident required assistance with self-care and received nothing by mouth. The resident had a tube feeding due to difficulty swallowing and tube feedings and water flushes were to be administered as ordered. The resident had a nutritional problem or potential nutritional problem. Interventions included the resident received nothing by mouth and received Jevity 1.5 at 50 milliliters for 1000 milliliters total volume. The 4/19/2024 progress note by registered diet technician #13 documented the resident had a diagnosis of aspiration pneumonia (inhalation of food/fluid into the lungs), received nothing by mouth, received tube feedings of Jevity 1.5 at 50 milliliters an hour for a total of 1000 milliliters, and weighed 109.2 pounds. A Mini-Nutritional Assessment was completed, and the resident score was 5.0, which was considered malnourished. The 4/19/2024 registered dietitian #14 nutritional assessment documented the resident received nothing by mouth, weighed 109.2 pounds, their body mass index was 21.3 which was considered low, and had impaired swallowing. Their estimated daily nutritional needs were 1500-1750 calories, 50-60 grams of protein, and 1500-1750 milliliters of fluids. The resident received tube feedings of Jevity 1.5 at 50 milliliters an hour for total volume of 1000 milliliters with 50 milliliters water flushes before and after tube feeding administration. This provided 1500 calories, 49.6 grams of protein, and 1860 milliliters of water. The tube feeding met greater than 100% of the resident's daily nutritional needs and weights would continue to be monitored. The 4/19/2024 occupational therapist #19 evaluation and plan of treatment did not address the resident's eating ability. The 4/19/2024 speech language pathologist #18 therapy evaluation and plan of treatment documented the resident received nothing by mouth and the recommendation was to continue nothing by mouth and they would trial honey thick liquids and pureed solids. The 4/22/2024 speech language pathologist #18 evaluation and plan of treatment documented recommendations for puree textured solids and honey thick liquids. The 4/23/2024 physician order documented the resident was to receive a pureed texture solids and honey thick liquid diet, in addition to enteral feedings. On 4/24/2024, the comprehensive care plan was updated to include the resident was dependent on 1 person for eating. The 4/24/2024 registered diet technician #13 progress note documented the resident was seen by the speech language pathologist and was upgraded to pureed solids and honey thick liquids. On 4/26/2024 the resident's record documented they weighed 106.3 pounds, a loss of 2.9 pounds/ 2.66% in 8 days. There were no additional documented weights after 4/26/2024. The 4/30/2024 physician order documented puree texture and nectar thick liquids, in addition to enteral feedings. (continued on next page)

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	335548	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/1/20204 registered diet technician #13 progress note documented the resident preferred only naturally pureed items on their pureed diet, the meal plan was updated to only included naturally pureed items such as applesauce, mashed potatoes, pudding, etc. The 5/1/2024 licensed practical nurse #22 progress note documented the resident complained of nausea and vomiting and wanted their tube feeding stopped. The 5/3/2024 registered dietitian #14 progress note documented the resident was refusing their tube feeding related to nausea and vomiting. Bolus (given all at once) tube feedings of Osmolite 1.5 would be provided 4 times daily at 237 milliliters for a total volume of 948 milliliters with 100 milliliter water flushes before and after tube feeding administration. The tube feeding would provide 1420 calories, 60 grams of protein, and a total of 1540 milliliters of water. Additionally, the resident received puree solids and nectar thick meal trays. The progress note did not address the resident's weight. The 5/3/2024 physician order documented enteral feedings were changed to Osmolite 1.5 (tube feeding formula) at 237 milliliters 4 times daily via gastrostomy tube. Administer 100 milliliters of water 4 times daily before and after each tube feeding administration. The undated care instructions (Kardex) documented the resident was dependent for eating. The resident's meal intakes from 5/6/2024-5/9/2024 documented intakes ranged 0-25% for 3 meals and 2 refusals. During an observation on 5/7/2024 at 12:45 PM, certified nurse aide #10 brought the resident's lunch tray to their room then left the room. The resident's meal tray included fortified pudding, yogurt, fortified mashed potatoes, nectar thick water, and nectar thick juice. Their food was unopened, and the resident stated they would not eat their meal. At 1:21 PM, the resident's meal tray remained untouched, and they were not in their room. During an observation on 5/9/2024 at 8:44 AM, the resident was in their room with a breakfast tray. The meal ticket documented nectar thick coffee, yogurt, nectar thick juice, and fortified pudding. The resident had a white colored drink in a cup and their fortified pudding was missing. All items were unopened and there was no staff present in their room. The resident was drinking 1 carton of Boost very high calorie (oral nutritional supplement). At 9:33 AM, certified nurse aide #15 removed the resident's tray from their room. The resident had only consumed 100% of their Boost very high calorie supplement and 0% of the other items. During an interview on 5/9/2024 at 11:05 AM certified nurse aide #15 stated weights were obtained as ordered. The registered diet technician puts up a weight list and staff obtained the weights of the residents on their assignment. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 11:58 AM registered diet technician #13 stated new admission's weights were obtained on admission, weekly for 4 weeks, then monthly if not clinically indicated to be weighed more frequently. If a resident refused to be weighed staff should document the refusal. If weights were missing, they sent an email to the Nurse Managers and the Director of Nursing to help aide with obtaining missing weights. Resident #75 weighed 109.2 pound on admission and on 4/26/2024 they weighed 106.3 pounds. There was 1 week of missing weights and the current week's weight had not yet been done. The resident received fortified foods to aide with nutritional support at mealtimes but received most of their nutritional needs from their tube feeding. The resident was care planned to receive fortified foods and they should be provided. The resident's nutritional needs had not been reassessed since admission. It was important to obtain weights as ordered to establish a baseline weight and to monitor the resident's nutritional status. During an interview on 5/9/2024 at 12:35 PM the Director of Therapy stated the nursing department assessed the resident's eating status on admission. The therapy department would make recommendations for activities of daily living, including eating status. It was important for the care plan to reflect the resident's status to provide the correct level of assistance. Resident #75 was not assessed for their eating ability on admission due to their order of nothing by mouth. Nursing staff documented they were dependent for eating related to their need for tube feedings. The therapy department did not address their eating status once the resident was started on a pureed diet, but they were followed by the speech language pathologist who recommended their current diet. It was nursing staff's responsibility to update the care plan. If the care plan indicated, they were dependent for eating that meant someone should be with the resident assisting them with their meals. During a telephone interview on 5/9/2024 at 12:46 PM registered dietitian #14 stated they worked remotely and did not come to the facility. Staff should be obtaining weights as ordered as it was important to establish a baseline weight and to monitor the resident's nutritional status. The resident currently received tube feedings and meal trays of pureed solids and nectar thick liquids. Their tube feedings were meeting their estimated needs without their meal trays so if they did not eat a meal, it was ok. The resident should be receiving all their ordered items on the meal tray. During an interview on 5/9/2024 at 1:51 PM certified nurse aide #17 stated a resident's eating status was listed in the care plan in the computer. If a resident was listed as dependent that meant staff should open their items and assist them with their meal. They stated Resident #75 did not eat well but fed themselves after set-up. The resident was on their assignment today and ate 50% of their breakfast. Staff should make sure the meal ticket matched the items on the tray. During an interview on 5/9/2024 at 1:59 PM Regional Registered Nurse #1when Resident #75 was admitted it was documented they were dependent for eating due to their need for tube feeding as they did not receive anything by mouth. The resident's current care plan documented they were dependent for eating and they now received meal trays. If staff noticed a discrepancy in the care plan, they should tell the nurse so it could be fixed for safety reasons. The care plan should be specific to the resident's needs and be accurate. Residents should be weighed as ordered and receive all items on their meal tray. If staff was unable to weigh a resident or the resident refused it should be documented. If an item was missing from a meal tray, staff should tell a nurse and the items should be obtained from the kitchen. If the care plan documented the resident was dependent for eating staff should be in the room assisting them with their meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2024 at 4:52 PM the Director of Nursing stated Resident #75 was admitted with a tube feeding and received nothing by mouth. When their diet order changed to include meal trays, they should have been evaluated to determine their level of assistance for feeding. Their current care plan documented they were dependent with meals which meant staff should be assisting them. Staff should be checking the meal trays to ensure all items are on the tray and ask the kitchen to send any missing items. Staff should obtain weights as ordered and let a nurse know if the resident refused. 10NYCRR 415.12(i)(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48675 Based on observation, interview, and record review during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure that a resident who required dialysis received services consistent with professional standards of practice for 1 of 1 resident (Resident #45) reviewed. Specifically, Resident #45 received hemodialysis (a treatment that filters the blood), had a physician order to remove the dialysis access site dressing 6-8 hours after dialysis and the dressing was scheduled to be removed prior to going to dialysis and was not completed. Findings include: The Entrance Conference Worksheet provided to the facility on [DATE] included information needed from the facility regarding dialysis contracts, agreements, arrangements and policies and procedures. The facility responded they did not currently have any residents who received dialysis. There was no documented evidence of a hemodialysis agreement or policy and procedures. Resident #45 had diagnoses including end stage renal disease (kidney disease) and dependence on renal dialysis. The 4/16/2024 Minimum Data Set assessment documented the resident was cognitively intact and received hemodialysis. The comprehensive care plan initiated 4/11/2024 documented the resident needed hemodialysis related to end stage renal disease and nonadherence to prescribed fluid restrictions. Interventions included the resident received dialysis on Monday, Wednesday, and Friday. Monitor left arm arteriovenous fistula (tube or device surgically implanted to create an artificial connection between an artery and a vein for dialysis access) for bruit (rumbling or whooshing sound) and thrill (a rumbling or buzzing sensation) every shift; monitor/document/report signs and symptoms of infection to access site including redness, swelling, warmth, drainage, or bleeding; and check and change dressing daily at the access site if ordered by the provider. The 4/12/2024 physician orders documented: - Hemodialysis: remove arteriovenous dressing 6-8 hours post (after) dialysis on Monday, Wednesday, and Friday. - Arteriovenous fistula: monitor for bruit and thrill every shift and notify provider for absence. Monitor for bleeding, if noted, apply pressure, and notify provider. No blood pressure in left arm. - dialysis 3 times a week on Monday, Wednesday, and Friday. Pick up time at 10:00 AM for a chair time of 11:00 AM. During an observation on 5/6/2024 at 8:53 AM, Resident #45 was sitting in their room on the edge of their bed. They stated they went to dialysis Monday, Wednesday, and Friday. They stated their fistula access site was on their left upper arm, and they removed their fistula dressing themself on Sunday night. The nursing staff rarely looked at their fistula and never removed the dressing so they would remove it themselves before they returned for their next dialysis session. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/9/2024 at 1:08 PM, Resident #45 was in their room wearing a short sleeve shirt, with a white gauze dressing fully covering their left upper arm from their armpit to their elbow. They stated nursing staff had not looked at their access site or offered to remove their dressing since they returned from dialysis late in the afternoon on 5/8/2024. They planned on removing their own dressing Friday morning before they went back to dialysis. The May 2024 Treatment Administration Record from 5/1/2024- 5/9/2024 documented the arteriovenous shunt dressing was to be removed 6-8 hours post dialysis on Monday, Wednesday, and Friday between 7:00 AM and 10:00 AM. The order was signed by licensed practical nurse #2 with a 3 (resident out of facility) on 5/8/2024 (Wednesday, the resident's scheduled dialysis time was 11:00 AM). The May 2024 Treatment Administration Record from 5/1/2024-5/9/2024 documented the resident was to be monitored every shift for complications: check for bruit, thrill, bruising, and bleeding. The order was signed as completed by licensed practical nurse #2 on 5/9/2024 for the 6:00 AM- 2:00 PM shift. During an interview on 5/9/2024 at 1:59 PM, licensed practical nurse #2 stated before Resident #45 went to dialysis, they were responsible for obtaining their vital signs and filling out their dialysis communication book. When the resident returned from dialysis, they would have a dressing covering their access site and they would monitor the site for complications and bleeding every shift. The dressing would remain on for a few hours after dialysis before the nurse would remove it. They stated the resident had not returned last evening on 4/8/2024 before they left and if the dressing was still on the following day, they would have removed it. They monitored the access site during the day shift and did not think the dressing was still in place or they would have removed it. If there was a big bulky dressing covering Resident #45's upper arm, it would make it more difficult to monitor the access site, but they thought they could still listen for bruit and thrill. They stated it was important to monitor the access site and remove the dressing as ordered so the dialysis site could be seen and monitored for bleeding, or signs of infection. During an observation on 5/9/2024 at 3:19 PM, Resident #45 was lying in bed with their eyes closed. They had a white gauze dressing fully covering their left upper arm from their armpit to their elbow. During an interview on 5/10/2024 at 10:26 AM, Regional Registered Nurse #1 stated if there was an order to remove a dialysis access site dressing, they expected it to be removed per the physician order. If the dressing was still on the following day, they expected the nurse to remove it as soon as possible. They stated there was no reason the dressing should have remained in place the following day if the nurse documented they monitored the access site as ordered. It would have made it difficult to see the site with a dressing covering it. They stated it was important to remove the dressing as ordered so the access site could be visualized and monitored for complications and signs and symptoms of infection. 10 NYCRR 415.12(K)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44838 49448 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, 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 1 of 2 medication carts (Medication cart #2 on South unit) reviewed. Specifically, medication cart #2 on the South unit had an insulin lispro pen (short acting insulin) for Resident #25 that was not dated with an opened or expiration date; an insulin glargine pen (long acting insulin) for Resident #62 that was not dated with an opened or expiration date; and an Anoro Ellipta inhaler (used to treat chronic lung disease) for Resident #72 that was not dated with an opened or expiration date. Findings include: The facility policy Medication Storage revised 1/2019 documented medications were stored in a manner that maintained the integrity of the product, ensured the safety of residents and was in accordance with department of health guidelines. Expired medications were removed from the medication storage areas and disposed of. During an observation of the South unit medication cart #2 on 5/7/2024 at 2:25 PM with licensed practical nurse #31 there were 4 insulin pens stored in the top drawer of the cart. 2 of 4 had no date opened (Resident #25 insulin lispro pen, and Resident #62 insulin glargine pen). There was an Ellipta Anoro inhaler labeled for Resident # 72 that did not have a date opened or discard date on the inhaler. Licensed practical nurse #31 stated insulin expired 28 days after opening and the nurse that opened the medication was responsible for dating the insulin. Insulin opened/ expiration dates should be checked prior to the medication being administered. Expired insulin may not work as intended and may not control blood sugars appropriately. They stated they were not sure if inhalers required an opened or expiration date. During an interview on 5/7/2024 at 2:40 PM registered nurse Unit Manager #5 stated they performed cart audits once a month and checked for expired medications. Insulin pens needed to be dated with an opened date as they expired 28 days after being opened. Without an opened date it would be unknown if the insulin's integrity was maintained. The nurse that opened the insulin was responsible for dating it. Any nurse that administered insulin should check the date on the pen and ensure the medication was not expired prior to it being administered. If expired medications were administered, they could be less effective and could result in unintended side effects. They were not sure if inhalers needed a date opened. During a follow up interview on 5/7/2024 at 3:30 PM with registered nurse Unit Manager #5, an unnamed pharmacist reported to them that the Anoro Ellipta inhaler expired 6 weeks after being opened. 10NYCRR 415.18(d)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 Based on observation and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and appetizing for 2 of 2 test trays (5/7/2024 and 5/8/2024 lunch trays) reviewed. Specifically, on 5/7/2024 the beef stew was 114 degrees Fahrenheit and the green and yellow bean mix was 108 degrees Fahrenheit; and on 5/8/2024 the French-fried potatoes were cold and undercooked. Findings include: The facility Beef Stew recipe documented hold food for service at an internal temperature of 140 degrees Fahrenheit. The facility policy Meal Service last revised 1/2023, documented meals would be served promptly to maintain adequate temperature and appearance. During an interview on 5/6/2024 at 8:37 AM, Resident #66 stated the food was cold. During the lunch meal observation on 5/7/2024 at 12:00 PM, the temperature of the food on the meal service line was checked. The beef stew was 173 degrees Fahrenheit, yellow and green bean mix was 168 degrees Fahrenheit, vegetable soup was 180 degrees Fahrenheit, and mashed potatoes were 182.5 degrees Fahrenheit. During an observation on 5/7/2024 at 12:31 PM, the meal cart left the kitchen and was brought to the North unit. At 12:37 PM, the last meal tray was tested for taste, temperature, and appearance (the resident was provided a replacement meal tray). The beef stew was 114 degrees Fahrenheit, the yellow and green bean mix was 108 degrees Fahrenheit, the coffee was 123 degrees Fahrenheit, and the milk was 46 degrees Fahrenheit. During the lunch meal observation on 5/8/2024 at 12:29 PM, the temperature of the food on the meal service line was checked. The barbecue chicken was 165 degrees Fahrenheit, mashed potatoes were 153 degrees Fahrenheit, and the mixed vegetables were 146 degrees Fahrenheit. During an observation on 5/8/2024 at 12:51 PM, room [ROOM NUMBER]'s lunch tray was tested for taste, temperature, and appearance (the resident was provided a replacement tray). The barbecue chicken was 128 degrees Fahrenheit, the mixed vegetables were 118 degrees Fahrenheit, the milk was 54 degrees Fahrenheit, and the coffee was 132 degrees Fahrenheit. The French-fried potatoes were cold and undercooked. During an interview on 5/8/2024 at 2:03 PM the Food Service Director stated the French fries from lunch were a frozen product and baked in the oven. They stated they were checked by staff before they were served, and they were not sure why the fries were not fully cooked. They stated test trays were completed 1-2 times a week and documented. The facility did not provide documentation of test trays when requested on 5/10/2024 from the Administrator. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 5/10/2024 at 11:18 AM the Food Service Director stated the appropriate serving temperatures for hot food items was 140-145 degrees Fahrenheit. The facility did not have plate warmers so that could lead to food not holding proper temperature. They stated the beef stew and bean mix were not served at proper temperatures. They made sure the food tasted good, and the [NAME] Supervisor also tasted the food prior to serving meals to ensure it was cooked completely and appealing to the residents. 10NYCRR 415.14(d)(2) 48675

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 43754 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure residents received and the facility provided a diet in a form designed to meet individual needs for 1 of 1 resident (Resident #33) reviewed. Specifically, Resident #33 was provided food items that were not consistent with their physician ordered diet. Findings include: The facility policy Modified Food Consistency last reviewed 2/2023, documented the texture and consistency-modified diets would be individualized with modifications made by the speech/language pathologist and physician in conjunction with the registered dietitian nutritionist and Director of Food and Nutrition services. A written order was needed. Resident #33 had diagnoses including dementia, diabetes, and cervicalgia (neck pain). The 4/25/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required supervision or touching assistance with eating, did not have a swallowing disorder, and did not receive a mechanically altered diet. The comprehensive care plan initiated 4/24/2024 documented the resident had potential nutritional problems related to stroke, dementia, and diabetes. Interventions included diet and consistency as ordered, mechanical soft, thin liquids. The 5/3/2024 physician order documented a controlled carbohydrate, mechanical soft texture diet, thin (regular) consistency diet. During an observation on 5/7/2024 at 12:37 PM, the tray for Resident #33's lunch tray was selected as a test tray as it was delivered by Certified Nurse Aide #15 (a replacement tray was requested). The resident's meal ticket documented a mechanical soft diet and thin liquids. Menu items included ground beef stew, no peas, and a biscuit cut up and moistened. The tray contained cut up biscuit covered by beef stew with chunks of beef larger than one inch. The facility menu extension sheets for Week 3, Tuesday Day 17 documented the mechanical soft beef stew was to be ground with no peas. During an interview on 5/9/2024 at 11:26 AM, Certified Nurse Aide #15 stated they gave the trays to the residents, set them up, and asked if they had any questions. They stated they did not check the tray and ticket for every resident, only if someone was new to the facility. During an interview on 5/9/2024 at 4:34 PM, [NAME] Supervisor #36 stated they prepared the beef stew on 5/7/2024. The regular stew was prepared with roasted beef tips and the mechanical soft and puree was prepared with sliced roast beef, two different meat products. They stated the mechanical soft was sliced thin, then ground, and put through a food processor. They stated the described stew on Resident #33's tray was for the regular diet and had roasted chunks of beef tips. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/10/2024 at 11:18 AM, the Food Service Director stated the kitchen staff were responsible for checking the trays and ensuring each resident received the correct consistency. Staff were trained on correct consistencies. The modified diet order came with the resident from the hospital, the registered dietitian would put that into the system, and speech therapy would check the resident when they came into the facility. They stated it was important for residents to receive the correct consistency to prevent them from choking. During an interview on 5/10/2024 at 1:27 PM Speech Language Pathologist #18 stated residents were screened upon admission, and they made recommendations for food consistency. It was important the resident received the correct consistency because they could be at risk of complications such as aspiration (inhaling food/fluid into the lungs), weight loss, and malnutrition. 10NYCRR 415.14(d)(3)

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Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40803 Based on observation, record review, and interview during the recertification and abbreviated (NY00312922) surveys conducted 5/6/2024-5/10/2024 the facility did not ensure each resident received at least three meals daily at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests and plans of care for 2 of 2 nursing units (North unit and South unit) observed. Specifically, resident meal trays were delivered to nursing floors up to 1 hour and 25 minutes after the scheduled mealtimes. Findings include: The facility policy Meal Service revised 4/2022 documented meals would be delivered promptly to assure quality. During an interview on 5/6/2024 at 8:30 AM Resident #19 stated sometimes the meals came late due to the kitchen being short staffed. The facility's posted schedule documented the following mealtimes: Breakfast: -North Unit 8 AM. -South Unit 8:15 AM. -Dining room [ROOM NUMBER]:35 AM and 8:45 AM. Lunch: -Dining room [ROOM NUMBER]:15 PM and 12:25 PM. -North Unit 12:35 PM. -South Unit 12:45 PM. The following observations were made on the North Unit: - on 5/6/24 at 9:25 AM, the 1st breakfast cart arrived on the unit, and at 9:37 AM, the second breakfast cart arrived on the unit. - on 5/8/24 at 8:51 AM, the 1st breakfast cart arrived on the unit and the 2nd breakfast cart arrived on the unit at 9:08 AM. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 5/9/24 at 8:21 AM, the 1st breakfast cart arrived on the unit and at 8:57 AM, the 2nd breakfast cart arrived on the unit. - on 5/10/2024 at 8:57 AM, the 1st breakfast cart arrived on the unit and at 9:24 AM the 2nd breakfast cart arrived on the unit. The following observations were made on the South Unit: - on 5/6/24 at 8:49 AM, the breakfast cart arrived on the unit. - on 5/8/2024 at 8:43 AM, the breakfast cart arrived on the unit. During an interview on 5/8/2024 at 11:46 AM licensed practical nurse #2 stated the breakfast meal trays should be delivered to the North Unit at 8:30 AM and the lunch meal trays should be delivered to the North Unit 12:15 PM-12:30 PM. The meals sometimes did not come on time as the kitchen was short staffed. The nursing units were not made aware if the meals were going to be late. During an interview on 5/8/2024 at 12:28 PM registered diet technician #13 stated 9:25 AM was late to be served breakfast as the meal was scheduled to come to the unit at 8:00 AM. Meals should be served as close as possible to the scheduled times. During an interview on 5/9/2024 at 12:46 PM registered dietitian #14 stated they worked remotely and did not come into the facility. They did not provide any oversight to the foodservice staff and meals should be served per the facility's schedule. During an interview on 5/10/2024 at 10:56 AM the Food Service Director stated the meal schedule indicated the 1st cart was to arrive to the North Unit at 8:00 AM. The kitchen had staffing issues and they were told it was ok if the North Unit was not served until 8:30 AM. They had just started at this facility a couple of months ago and had not been able to observe what time the meal carts were leaving the kitchen as they were short staffed. It was difficult to get the meals out on time if staff called in since they were already short staffed. Staff should be following the posted mealtime schedule. 10 NYCRR 415.14(f)(3)(4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43754 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, the main kitchen walk-in cooler floor and door, walk-in freezer door, hood filters, the wall beside the coffee station, and the ceiling were in disrepair and there were several unclean surfaces present throughout the kitchen. Findings include: The Food Service Department policy Cleaning Policy last reviewed 1/2023 documented the nutrition and food service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. There was no documented evidence of a kitchen cleaning schedule. During an initial main kitchen tour on 5/6/2024 the following was observed: - at 6:11 AM, one filter was out of place at the right end of the hood above the flat top stove. - at 6:20 AM, the door to the walk-in freezer would not shut completely and there was notable frost inside the door. The door was broken and separated at the bottom where it hit the floor of the walk-in cooler. There was significant food debris and a small puddle of liquid on the floor on the inside of the walk-in freezer. - at 6:22 AM, the walk-in cooler floor tiles were cracked and shattered, most of the floor was covered by black rubber mats but moved freely and was loose from the broken tiles beneath the mats. There were large brown spills (mostly dried but still slightly tacky) under the back right rack. The broom and dustpan were in the middle of the cooler perched over a puddle of liquid. The door to the walk-in cooler was ajar and would not close completely. - at 6:37 AM, there was water dripping through a light fixture by the hand wash sink. There was a water leak between the tray line and the upright double door cooler coming through a light fixture. Both of those lights were not working. Both leaks were over the aisles on either end of the tray line service area. Staff walked through the puddles to get to the tray line and cook areas. During an additional tour of the kitchen on 5/7/2024 the following was observed: - at 11:37 AM, there was a hood filter at the end above the flat top that was out of place and two filters on the opposite side were broken. - at 11:39 AM, there were some loose canned goods and food debris under the shelving unit and between the equipment on the cookline. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 11:41 AM, there were heavy coffee stains dried onto the table below the coffee machine. - at 11:43 AM, there were unfinished drywall patched areas of wall penetrations to the left of the coffee area, they were not smooth and easily cleanable. The wall behind the coffee station was soiled by brown dried on water marks that ran from the shelf to the floor. - at 11:51 AM, the walk-in cooler floor was in disrepair with numerous broken, cracked tiles, and the floor moved under foot as staff stepped across the parts that were covered by black rubber mats. The walk-in freezer floor was soiled by puddles of unknown liquid and there was food debris under the shelving. The walk-in cooler door hit the latching mechanism at the top of the door which prevented it from closing completely. The walk-in freezer door was falling apart and was unable to be closed completely. The door was split at the bottom and separated when it hit the floor of the walk-in cooler as it was opened. During an observation on 5/08/24 at 12:26 PM, there was water dripping through a light fixture by the hand wash sink. There was a water leak between the tray line and the upright double door cooler coming through a light fixture. Both of those lights were not working. Both leaks were over the aisles on either end of the tray line service area. Staff walked through the puddles to get to the tray line and cook areas. During an interview on 5/09/2024 at 4:34 PM, [NAME] Supervisor #36 stated when something was broken, or required maintenance they would verbally report that to the Food Service Director and then to the maintenance staff. They stated the walk-in cooler floor had been shattered for a couple of months which the Maintenance Director was supposed to replace. The ceiling had been leaking for at least a year and was a problem since last winter. The walk-in freezer door was scheduled to be fixed or replaced and had been broken for the last couple of months. They were not sure if there was documentation for any of the repairs that were needed in the kitchen. The kitchen was supposed to be cleaned every day, and they did not document the cleaning anywhere. During an interview on 5/10/2024 at 11:18 AM, the Food Service Director stated the walk-in cooler floor, walk-in freezer door, and ceiling leaks had been like that since they started a few months ago. They were told they were in the process for getting them fixed or replaced. They stated they had some documented emails regarding some of the repairs. They stated they were not aware of the hood filter that was out of place, or the two that were broken. It was not a safe sanitary environment with the broken equipment and leaks in the kitchen. The kitchen was supposed to be cleaned every day and that was not documented. They stated it was important for the kitchen equipment to be properly maintained and cleaned to prevent the spread of germs, cross contamination, and food borne illness. During an interview on 5/10/2024 at 5:30 PM, the Administrator stated they did not have any documentation for the repairs that were planned and needed in the kitchen. NYCRR10 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 40803 43754 44838 48675 Based on observation, record review, and interview during the recertification and abbreviated (NY00312922 and NY00310431) surveys conducted 5/6/2024-5/10/2024, 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 2 of 10 residents (Residents #36 and #45) reviewed and the facility lacked a water management plan to reduce the risk of growth and spread of Legionella (a bacteria found in water systems). Specifically, staff was observed not wearing the required personal protective equipment in Resident #45's room who was on transmission-based precautions; and Resident #36 had extended-spectrum beta-lactamase (enzyme resistant to most antibiotics) in their urine with an indwelling medical device and enhanced barrier precautions were not properly maintained. Additionally, the facility did not have a water management plan that detailed their policy and procedures for reducing the risk of growth and spread of Legionella and other opportunistic pathogens. Findings include: The facility policy Enhanced Barrier Precautions reviewed 5/18/2023 documented staff was required to wear a gown and gloves while high-contact care activities were performed. Face protection might be needed if they were performing activities with a risk for splashing or spraying. Enhanced barrier precautions would be initiated for residents with any of the following: infection or colonization with a multi-drug resistant organism, indwelling medical devices including but not limited to, urinary catheters, feeding tubes, central lines, and wounds. High-contact resident activities included bathing/showering in a resident room or shared/common shower room, transfers, hygiene, dressing, changing bed linens, changing briefs, assisting with toileting, care of an indwelling medical device, and wound care. Hand hygiene was performed before and after resident contact and after removing gown and gloves within the resident's room. Initiation or discontinuation of enhanced barrier precautions did not require a physician order but would be initiated or discontinued by the infection preventionist or designee. An enhanced barrier precautions sign was placed outside the resident's room to indicate precautions were in place and personal protective equipment would be readily available near the entrance to the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Transmission-Based Precautions revised 4/25/2024 documented transmission-based precautions was a second tier of infection control which was implemented in addition to standard precautions based upon modes of transportation (contact, droplet, airborne). Droplet precautions referred to actions designated to reduce the spread of pathogens through close respiratory or mucous membrane contact with respiratory secretions. Upon entering the room of a resident on droplet precautions, healthcare personnel and visitors would put on a face mask. Additional personal protective equipment was recommended based on anticipated risks of exposure. Hand hygiene was performed before and after resident contact and after removing personal protective equipment within the resident's room. Single resident equipment would be used if possible and shared resident equipment would be cleaned and disinfected between each resident. Transmission based precautions would be initiated or discontinued by the infection preventionist or designee. Signage was placed outside the resident's room and would provide instruction to the type of precautions implemented with guidance to healthcare personnel and visitors (hand hygiene, gown, gloves, mask, or eye protection). Personal protective equipment would be readily available near the entrance to the resident's room. 1) Resident #45 had diagnoses including pneumonia (infection in the lungs), sepsis due to methicillin susceptible staphylococcus, and end stage renal disease (kidney disease). The 4/16/2024 Minimum Data Set assessment documented the resident was cognitively intact, had intravenous access (thin tube inserted into a vein), was on intravenous antibiotics, required partial/moderate assistance with toileting hygiene, shower/bathing self, and supervision/touching assistance with personal hygiene, oral hygiene, upper body dressing, and transfers. The comprehensive care plan initiated 4/11/2024 documented Resident #45 had suspected/actual infection-pneumonia in bilateral lungs. Interventions included administer antimicrobials (medications used to treat infections) as ordered, monitor for symptoms/sepsis, applicable personal protective equipment was to be worn by staff, providers, and visitors, and maintain proper infection control precautions. The comprehensive care plan imitated on 4/11/2024 documented Resident #4 had a central line catheter. Interventions included change dressing weekly, explain purpose of intravenous therapy including infusion pump, and to monitor every shift for abnormalities. Physician orders documented: - on 4/23/2024- change central line dressing every 7 days. - on 5/1/2024- Cefazolin (antibiotic) solution 1 gram intravenously once a day for pneumonia until 5/11/2024. The orders did not include transmission-based precautions. During an observation and interview on 5/6/2024 8:53 AM, Resident #45 was seated on the edge of their bed, in their room. They stated they were admitted to the facility after being hospitalized for pneumonia and continued to get antibiotics once a day through the central line catheter on the right side of their neck. No transmission-based precaution sign or personal protective equipment was observed outside of their room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/7/2024 at 9:16 AM, Resident #45's room had a green droplet precaution sign and a 3-drawer plastic container filled with gloves, gowns, eye protection, and facemasks outside of their room. The green sign had pictures of gloves, yellow gown, eye protection goggles, and a facemask. Instructions included: clean hands before entering and leaving the room, make sure eyes and mouth were fully covered before entry, remove face protection before exiting. During an observation on 5/7/2024 at 12:44 PM, a green droplet precaution sign was on the wall outside Resident #45's room. Certified nurse aide #3 entered the room carrying the resident's lunch tray. They did not perform hand hygiene, their blue facemask was below their nose, and they did not put on any additional personal protective equipment. Certified nurse aide #3 exited the room without performing hang hygiene, their mask was below their nose, and they walked to the meal cart and picked up another resident's lunch tray. During an observation on 5/7/2024 at 1:12 PM, a green droplet precaution sign was on the wall outside Resident #45's room. Licensed practical nurse #32 entered the room wearing a blue facemask and pushing a portable vital sign machine. They did not perform hand hygiene or put on any additional personal protective equipment. They obtained vital signs from Resident #45, walked over to Resident #66, and obtained vital signs without cleaning or sanitizing the machine. At 1:16 PM licensed practical nurse #32 exited Resident #45's room wearing the same blue facemask and did not perform hand hygiene. They left the vitals machine outside the door and did not disinfect it. During an observation on 5/8/2024 at 11:15 AM, a green droplet precaution sign was on the wall outside Resident #45's room. licensed practical nurse #2 entered the room wearing a blue facemask, did not perform hand hygiene, and did not put on any additional personal protective equipment. At 11:19 AM licensed practical nurse #2 exited the room wearing the same blue facemask and performed hand hygiene using the wall dispenser. During an observation on 5/9/2024 at 1:06 PM, Resident #45 did not have a droplet precaution sign or personal protective equipment outside of their room. During an interview on 5/9/2024 at 1:56 PM, certified nurse aide #3 stated they received training upon hire and yearly on infection control which included transmission-based precautions. They would know what residents were on transmission-based precautions from their morning report. There should be bins with personal protective equipment, and signs outside the resident's room telling them that what type of precautions they were on. The signs were specific and told the staff what personal protective equipment was needed to enter a resident's room. They were unsure what the difference was between enhanced barrier precautions and droplet precautions. They were unsure if they should change their facemask when they went in and out of Resident #45's room. They stated they should read the sign before they entered the room. They stated it was important to wear their mask correctly covering their nose and mouth and to wear the appropriate personal protective equipment into Resident #45's room to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2024 at 2:06 PM, licensed practical nurse #2 stated they would know a resident was on transmission-based precautions by the signage on their door and they would be told in morning report. They were unsure who was responsible for placing the transmission-based precautions signage on resident's doors. They stated it was important to wear appropriate personal protective equipment into resident rooms to prevent the spread of infection. Resident #45 was not supposed to be on droplet precautions, and they were unsure who hung or removed the droplet precaution sign from Resident #45's room. They stated they received training on infection control and transmission-based precautions, but they were unsure what the difference was for contact, droplet, or enhanced barrier precautions. They would read the instructions on the signage outside the room and wear the appropriate personal protective equipment. During an interview on 5/10/2024 at 10:38 AM, regional registered nurse #1 stated the infection prevention nurse was not available and they were covering for them. There were multiple layers of staff involved in infection control so all residents should have the appropriate signage on their rooms. Annual infection control education was provided to staff and all staff were reeducated when there was any kind of outbreak within the facility. Any resident with an open wound, device, catheter, peg tube, multidrug-resistant bacteria, or intravenous catheter should be on enhanced barrier precautions. Resident #45 had a dialysis access site and an intravenous catheter, so they be on enhanced barrier precautions. They stated if staff saw a droplet precaution sign or any transmission-based precaution on a resident's door they expected staff to wear the appropriate personal protective equipment. Once the type of transmission-based precaution was verified a physician order would be put in the electronic medical record and the residents care plan would be updated. They stated all staff should stop and read the signage before entering a resident room. The signs were specific and indicated what personal protective equipment was needed to enter the room. 2) Resident #36 had diagnoses including sepsis (system wide infection) and extended-spectrum beta-lactamase resistance (a resistant enzyme found in some strains of bacteria). The 3/30/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent on staff for activities of daily living, had an indwelling catheter, and a multidrug-resistant bacteria. The comprehensive care plan initiated 10/19/2023 documented the resident was at risk for infection related to a history of urinary tract infections, urosepsis, and multidrug-resistant bacteria. Interventions included enhanced barrier precautions and applicable personal protective equipment was to be worn by staff, providers, family, and visitors. The 3/25/2024 physician orders documented contact precautions for extended-spectrum beta-lactamases in the urine. Enhanced barrier precautions every shift. During an observation on 5/6/2024 at 7:47 AM, Resident #36 had an enhanced barrier precaution sign on their door. Certified nurse aide #37 entered Resident #36's room without performing hand hygiene or putting on a gown. At 7:55 AM certified nurse aide #37 exited the room without a gown on and their facemask was below their nose, only covering their mouth. During an observation on 5/8/2024 at 12:06 PM, Resident #36 had an enhanced barrier precaution sign on their door. Certified nurse aide #37 and 2 unidentified certified nurse aides brought Resident #36 into their room for incontinence care, and they did not put on gowns. At 12:15 PM they exited the room with Resident #36, and they did not have gowns on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2024 at 10:43 AM, certified nurse aide #37 stated they were unsure if Resident #36 was on precautions. They stated they did not wear a gown while they provided care and it was not communicated to them that Resident #36 was on precautions. They stated they wore a facemask because they were told to, they did not have a flu shot, and sometimes the mask would fall below their nose. It was hard to breathe with the mask over their nose, but they made sure it was pulled up when they were around residents. They stated it was expected for them to always have the mask in place while on the unit and to wear gowns in precaution rooms to prevent the spread of infection. During an interview on 5/10/2024 at 10:38 AM, regional registered nurse #1 stated the infection prevention nurse was not available and they were covering for them. There were multiple layers of staff involved in infection control so all residents should have the appropriate signage on their rooms. Annual infection control education was provided to staff and all staff were reeducated when there was any kind of outbreak within the facility. Any resident with an open wound, device, catheter, peg tube, multidrug-resistant bacteria, or intravenous catheter should be on enhanced barrier precautions. They stated if staff saw a droplet precaution sign or any transmission-based precaution on a resident's door they expected staff to wear the appropriate personal protective equipment. They stated all staff should stop and read the signage before entering a resident room. The signs were specific and indicated what personal protective equipment was needed to enter the room. 3)Legionella The facility provided sample testing results for Legionella. In 2022, 14 samples were collected by the Director of Housekeeping and Laundry, with one positive result. On 9/6/2023, 14 samples were collected by the Maintenance Director and sent to the lab, but 2 samples were rejected. The chain of custody and the lab results did not identify why the two samples were rejected. One of the two samples that was not analyzed was the same location as the positive result in 2022. During an interview on 5/10/2024 at 12:18 PM, the Director of Housekeeping and Laundry stated they were not sure why all the samples sent in 2023 were not analyzed by the lab and they were told by the Maintenance Director that all the samples came back good. During an interview on 5/10/2024 at 12:18 PM, the Administrator stated the Maintenance Director was not available for interview during survey. They stated they did not find documentation for their water management plan and was unable to provide any documentation to show why not all the samples were analyzed in 2023. They stated they were unaware that one of the rejected samples was the same location as the positive sample in 2022. It would have been an important site to retest. The Administrator stated it was important that the facility maintained a proper water management plan for the health and safety of the residents and staff to prevent the spread of Legionella. 10NYCRR 415.19(a)(2)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 43754 Based on observation, interview, and record review during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not maintain equipment in safe operating condition for 2 of 2 unit kitchenette refrigerators. Specifically, the unit kitchenette refrigerators did not maintain proper temperatures. Findings include: During an observation on 5/6/2024 at 7:30 AM, the South Unit kitchenette had an upright white refrigerator labeled, out of order-do not use. The refrigerator portion was empty. The thermometer inside read 65 degrees Fahrenheit. The freezer portion held some frozen food items that included ice cream bars, frozen drinks, and individual portions of ice cream. Additionally, there was a small black refrigerator that had the door left ajar a few inches. There were drinks for resident use had a measured temperature of 41.7 degrees Fahrenheit. The door hit the side of the cooler and had to be physically pushed closed for the door to seal properly. During an observation on 5/6/2024 at 7:13 AM, the North Unit kitchenette refrigerator thermometer read 58 degrees Fahrenheit. The refrigerator contained 4 cottage cheese containers, 2 brownish pureed food containers, 3 tuna sandwiches, 2 jugs of thickened water, 1 plastic carafe of honey thick juice, and an unreadable plastic carafe with undated orange drink. During an observation on 5/6/2024 at 8:53 AM, the North Unit kitchenette refrigerator thermometer read 58 degrees Fahrenheit. The thickened dairy beverage was removed from the shelf and the temperature was measured at 55 degrees Fahrenheit. The temperature log on the refrigerator was documented as 36 degrees Fahrenheit 5/6/2024 by the Food Service Director. During an interview on 5/6/2024 at 9:00 AM, the Food Service stated they checked the North Unit kitchenette refrigerator. They stated they read the internal thermometer, which was brand new, and it read 36 degrees Fahrenheit at about 7:45 AM. The thermometer was now reading 60 degrees Fahrenheit. They stated someone may have left it open. The surveyor asked them to leave the refrigerator closed for 30 minutes to have the unit rechecked to see how the temperature would adjust. They stated they would see that no one opened the refrigerator. During an observation on 5/6/2024 at 9:05 AM, staff wheeled a new refrigerator down the hall to the North Unit kitchenette. At 9:25 AM the refrigerator was replaced. During an observation on 5/7/2024 at 10:06 AM, with the Director of Housekeeping and Laundry the South 100s kitchenette small refrigerator was removed, and the existing refrigerator was no longer labeled as do not use. The thermometer in the upright refrigerator read 60 degrees Fahrenheit and was confirmed by the surveyor's thermometer and measured at 58 degrees Fahrenheit. There was no food stored in the refrigerator. The freezer portion contained ice cream bars and the thermometer read 12 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
	335548	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onondaga Center for Rehabilitation and Nursing	217 East Avenue Minoa, NY 13116

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/07/24 at 10:06 AM, the Director of Housekeeping and Laundry stated when there was an issue with facility equipment the staff should fill out a maintenance request form. They were not sure if a form was completed for the refrigerator. During an interview on 5/10/2024 at 11:18 AM the Food Service Director stated the kitchenette refrigerator temperatures were checked by the kitchen staff twice daily and recorded on the log on each refrigerator. They stated the South Unit refrigerator went down last week; they had ordered a replacement which came in the morning of 5/6/2024. When they were informed the North Unit was not holding temperature, they sent the new one there instead and did not need to see if it was just left open. They thought they had some documentation regarding the timing of the South Unit going down and ordering the new one. Documentation regarding the temperature logs and the South Unit kitchenette refrigerator were not provided by the facility when requested from the Administrator on 5/9/2024 and 5/10/2024. 10NYCRR 415.29 10NYCRR 713-2.5

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44838 49448 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not ensure residents had a means of directly contacting staff for assistance for 1 of 1 resident (Resident #35) reviewed. Specifically, Resident #35's call bell was out of reach and not accessible. Findings include: The facility policy Call Bells revised 8/2019 documented timely response was provided to residents in need of assistance and was essential that high quality resident outcomes were ensured. When the resident was in bed staff ensured the call light was within easy reach of the resident. Resident #35 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (lung disease), heart failure, and atrial fibrillation (irregular heartbeat). The Minimum Data Set assessment dated [DATE] documented the resident had moderately impaired cognition and was dependent for toileting, bathing, transfers, and dressing. The comprehensive care plan initiated 12/30/2022 documented the resident was at risk for falls due to immobility. Interventions included call bell within resident's reach and use was encouraged for assistance as needed. The resident was observed with their call bell on the floor and out of reach: - on 5/6/2024 at 7:00 AM and 8:46 AM. - on 5/7/2024 at 9:05 AM, 12:02 PM, 12:52 PM and 1:44 PM. - on 5/8/2024 at 9:07 AM, 10:00 AM, and 11:14 AM. - on 5/9/2024 at 9:48 AM. During an interview on 5/9/2024 at 10:24 AM certified nurse aide #11 stated call bells were supposed to be in residents' reach. If the call bells were not in reach, they would not know if residents needed help, and this put them at higher risk for falls. Resident #35 was able to use their call bell and it should have been in reach. During an interview on 5/10/2024 at 9:00 AM licensed practical nurse #6 stated call bells should be in reach of the resident so their needs could be responded to, or a potential emergency could be communicated. Resident #35 was able to use their call bell and nursing staff should ensure call bells were within reach. (continued on next page)

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	335548	A. Building B. Wing	05/10/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/10/2024 at 9:53 AM registered nurse Unit Manager #5 stated Resident #35 was able to use the call bell and it should have been in their reach. It was important they had their call bell in reach so their needs could be communicated, and all staff were responsible to ensure call bells were in reach. 10NYCRR 415.5(e)(1)

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	335548	A. Building B. Wing	05/10/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 Based on observation, record review, and interview during the recertification survey conducted 5/6/2024-5/10/2024, the facility did not maintain an effective pest control program so that the facility was free of pests for 1 of 1 resident room. Specifically, there was evidence of mice in resident room [ROOM NUMBER]. Findings include: The third-party pest control vendor service reports documented resident room [ROOM NUMBER] was treated for mice and rodents on 1/17/2024, 3/6/2024, 3/13/2024, and 3/20/2024. The third-party pest control log dated 5/8/2024 did include documentation about mice or treatments for rodents in the facility. The log documented the facility was inspected and serviced. During an interview on 5/6/2024 at 8:22 AM, Resident #66 who resided in room [ROOM NUMBER] stated they had caught a mouse in their room recently but there was another they were still trying to catch. They stated they had a mouse come out of the heater the past two nights in a row. The mouse ran out of their room and into the hall. Resident #66's roommate, Resident #45, confirmed the mice sighting. During an observation and interview on 5/6/2024 at 9:12 AM, the Director of Housekeeping and Laundry opened the cover to the heater in resident room [ROOM NUMBER]. Rodent droppings and chewed candy wrappers were inside and throughout the heater. The top of the heater had an open hole through the casing material which allowed potential pests to enter and exit the unit. The Director of Housekeeping and Laundry stated that housekeeping was responsible for cleaning the outside of the units and maintenance did routine cleaning of the interior of the units every 6 months. During an observation on 5/6/2024 at 9:30 AM, the exterior of the heater to resident room [ROOM NUMBER] was observed. The exterior of the unit was angle metal slats approximately 1 inch apart. No other barrier could be seen to prevent pests from entering the heater units. During an interview on 5/20/2024 at 12:09 PM, the Administrator stated both housekeeping and maintenance were responsible for pest management. The Director of Maintenance was not available during survey. They stated when they had sightings, they were documented and relayed to their pest control vendor who would come out the same day or the next day. The Administrator stated it was important the facility was kept free of pests to prevent the spread of diseases. 10NYCRR 415.29(j)(5)