STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335579	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Center for Rehabilitation and Nursing	1045 West Street Carthage, NY 13619

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 33421 Based on record review and interview during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 1 of 3 residents (Resident #72) reviewed. Specifically, Resident #72 remained in the facility after discontinuation of Medicare Part A services and the facility did not provide the resident with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) for Medicare Part A as required. Findings include: The facility policy, Notice- Advances Beneficiary Notice, dated 7/2019 documented the Advance Beneficiary Notice of Non-coverage was to be issued by the facility where Medicare payment was expected to be denied. The notice must be provided within enough time to provide the beneficiary enough time to make an informed decision on whether or not to continue to receive services and accept potential financial liability not covered by Medicare. The notice must give a brief explanation why the beneficiary's needs did not meet Medicare coverage guidelines. The Center for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055, expiration date 1/31/26, documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending. Resident #72 had diagnoses including muscle weakness, anxiety, and traumatic brain injury. The 9/17/2024 Minimum Data Set assessment documented it was a Skilled Nursing Facility PPS (Prospective Payment System) Part A Discharge (end of stay) assessment with a start date of 7/1/2024 and an end date of 9/17/2024. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 letter documented Resident #72's effective end date of services was 9/17/2024. Business Office Manager #16's handwritten note documented the form was mailed to the resident's representative as the resident was unable to sign for themselves (no date documented when the form was mailed). The letter was not dated. The United States Postal Service Certified Mail Receipt addressed to the resident's representative did not document a date the letter was mailed by the facility. During an interview on 9/25/2024 at 4:21 PM, Business Office Manager #16 stated they sent the beneficiary letters as soon as the insurance company or therapy notified them of a pending cut from therapy. They should have put a date on the letter and certified mail forms when it was sent by the facility. There was no tracking mechanism by the facility. The resident remained in the facility and the facility charges were back dated and covered by Medicaid. The manager stated they should have documented when the letter was sent as it was to be sent at least 2 days prior to termination of services. During a telephone interview on 9/25/2024 at 4:30 PM, Resident #72's representative stated they received the beneficiary letter on 9/23/2024 from the post office and signed that the letter was received. The representative stated they would have appealed the non-coverage if they were aware earlier. They made numerous attempts to contact the facility regarding the reason for the discontinuation of services, and the facility had not called them back or given them an explanation as to why the resident was cut from therapy. 10 NYCRR 483.10 (g) (18)

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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** 48675 Based on record review, observation, and interviews during the recertification and abbreviated (NY00348460) surveys conducted 9/23/2024-9/26/2024, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 2 resident units (North and South units) reviewed. Specifically, the South unit common area had a stained carpet, four burned out lights, a broken light fixture, the unit shower was missing floor and wall tiles, and the dining room countertop was damaged; the North unit resident room [ROOM NUMBER] had a dirty floor mat that smelled of mildew and cobwebs on the wall. Findings include: The facility policy, Cleaning/Disinfecting Resident Care Items and Equipment, revised 3/13/2024, documented reusable resident care items and equipment would be cleaned and disinfected according to the current Center for Disease Control and Prevention recommendations for disinfection of healthcare facilities. The facility policy, Environmental Services: Vacuuming Carpets, revised May 2018, documented if there was a stain on a carpet it was cleaned according to the carpet cleaning procedure in order to maintain a safe and sanitary environment. The following observations were made on the North unit: - on 9/23/2024 at 11:03 AM, resident room [ROOM NUMBER]'s floor mat was dirty with dried debris and crumbs. When the mat was lifted there was a smell of mildew. There was a cobweb on the wall in the corner of the room. - on 9/24/24 at 8:31 AM, resident room [ROOM NUMBER]'s floor mat had dried debris. When the mat was lifted it smelled of mildew and the floor tiles were stained. There were cobwebs in the upper and lower corner of the wall above the mat. The following observations were made on the South unit: - on 9/24/2024 at 9:56 AM, the dining room countertop was damaged/chipped and the drawers under the countertop were loose and not aligned. - on 9/24/2024 at 10:08 AM, the unit shower room had multiple missing floor and wall tiles. - on 9/24/2024 at 10:26 AM, the unit hall bathroom had a broken wall tile at the bottom of the door. - on 9/24/2024 at 10:42 AM, the unit common area had several large, stained areas in the carpet, four burned out lights, and a broken light fixture. (continued on next page)

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	335579	A. Building B. Wing	09/26/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/2024 at 01:31 PM, Housekeeper #5 stated resident rooms should be mopped daily but they could not always be done because of short staffing. They stated floor mats were cleaned every day. If a resident was not in their room the mat was wiped down, set upright to dry, and the floor was mopped. If the resident was in their room the mat was wiped down but left in place. They stated it was important to clean the rooms and floor mats to prevent the spread of infection. During an interview on 9/25/2024 at 1:00 PM Licensed Practical Nurse #6 stated floor mats were ordered from maintenance and cleaned daily by housekeeping. If there was a small spill nursing staff should clean it, however if the floor mat required additional cleaning it was sent for a power washing. During an interview on 9/26/2024 at 10:38 AM Housekeeper #8 stated the day room rug was very stained and had not been shampooed in over one year because the porter was responsible for shampooing the rug and that position had been vacant for approximately one year. They stated the rooms had not been painted in nearly nine years. They stated the rooms and common areas were not homelike. During an interview on 9/26/2024 at 12:55 PM Maintenance Director #7 stated they were aware of the lights being out in the South unit common area. They were not aware of the other environmental concerns as there were no work orders for the shower tiles or countertops. They stated it was important to keep the environment homelike for the safety of both residents and staff. 10 NYCRR 415.29(j)(1)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48675 Based on observation, record review, and interviews during the recertification and abbreviated (NY00348460 and NY00345485) surveys conducted 9/23/2024-9/26/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 2 of 7 residents (Resident #15 and #43) reviewed. Specifically, Resident #43 was not assisted with removing unwanted facial hair, and Resident #15 had unkept hair and unclean and untrimmed fingernails. Findings include: The facility policy, Activities of Daily Living Care and Support, revised 3/13/2024, documented activities of daily living care and support would be provided for residents who were unable to carry out activities of daily living independently, 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. Nail care would be provided as needed for residents and facial hair would be groomed as per residents' preference and/or assessed needs. 1) Resident #43 had diagnoses including cerebral palsy (disorder that affects movement, muscle tone, and posture), muscle weakness, and repeated falls. The 7/8/2024 Minimum Data Set assessment documented the resident was cognitively intact, was dependent with toileting hygiene, shower/bathing, and lower body dressing, required setup or clean-up assistance with eating and oral hygiene, and did not refuse care. The comprehensive care plan initiated 6/14/2024 documented the resident required assistance with self-care and mobility related to impaired balance and limited mobility. Interventions included partial assistance with personal hygiene and substantial assistance with showering/bathing. The 9/2024 certified nurse aide care record documented the resident received personal care during the day and evening shift on 9/23/2024-9/25/2024. Resident #43 was observed at the following times: - on 9/23/2024 at 12:10 PM, in their room seated in their wheelchair. They had thick brown hair covering their upper lip and long gray/white hair under their chin. The resident stated they did not want facial hair. - on 9/24/2024 at 9:10 AM, in their room seated in their wheelchair. They had thick brown hair covering their upper lip and long gray/white hair covering their chin. - on 9/25/2024 at 9:38 AM, in their room seated in their wheelchair. They had thick brown hair covering their upper lip and long gray/white hair covering their chin. The resident stated they hoped staff had time to shave them because they did not want facial hair when they attended the Fall Festival activity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 1:10 PM, Certified Nurse Aide #34 stated they looked at the resident's care instructions to know how to properly care for each resident. Personal hygiene consisted of cleaning the resident head to toe, nail care, oral care, and shaving. They stated after they completed all personal hygiene, they documented the care was completed. If a resident refused, they would document the refusal and notify the nurse so they could reapproach the resident. They were familiar with Resident #43, they did not refuse care, and they assisted with their care that day. The stated they shaved the resident because they had a lot of facial hair, and they thought another certified nurse aide should have done it earlier that week when they were not working. It was important for the certified nurse aides to offer shaving whenever facial hair was present to maintain resident dignity. During an interview on 9/25/2024 at 3:42 PM, Licensed Practical Nurse #14 stated staff looked at a resident's care plan or care instructions to tell them how to properly care for the resident. Personal hygiene was completed each shift and consisted of washing a resident's face and body, nail care, hair care, shaving, and oral care. If a resident refused care, the certified nurse aides would notify the nurse so they could reapproach the resident. They had not been notified of any refusals by Resident #43. They stated it was important for the certified nurse aides to shave Resident #43 for their self-image and to maintain their dignity. During an interview on 9/26/2024 at 9:26 AM, Certified Nurse Aide #36 stated residents received showers twice a week and they would shave resident's when they were in the shower. They gave Resident #43 a shower on 9/23/2024 and they could not recall if they shaved the resident, but they normally would during a shower. Resident #43 never refused care but if they had, they would have notified the nurse. They stated it was important to shave Resident #43 whenever they had facial hair to maintain their dignity. During an interview on 9/26/2024 at 10:25 AM, the Assistant Director of Nursing stated personal hygiene consisted of oral care, bathing, dressing, nail care, and shaving. They stated personal hygiene should be offered and completed daily for each resident. The electronic documentation system only asked certified nurse aides if all care was completed, and they would answer yes or no. If a resident refused care, they should notify the nurse so they could reapproach the resident. It was important for the certified nurse aides to offer shaving whenever Resident #43 had facial hair to boost their self-esteem and to maintain their dignity. 2) Resident #15 had diagnoses including dementia, weakness, and need for assistance with personal care. The 6/30/2024 Minimum Data Set assessment documented the resident required modified independence for daily decision making, did not refuse care, and required maximum assistance for hygiene care. The comprehensive care plan initiated 3/4/2021 documented the resident required assistance with activities of daily living and was at risk for impaired skin integrity. Interventions included keep fingernails short to prevent scratches, showers on Tuesday and Friday evenings, and substantial assistance of one for personal hygiene tasks. The September 2024 Documentation Survey Report documented the resident received a shower on 9/24/2024 (Tuesday) by Certified Nurse Aide #25. There was no documentation the resident received a shower on 9/20/2024 (Friday). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #15 was observed in their room with long, jagged nails with brown debris and unkempt, matted hair on 9/23/2024 at 11:14 AM, 9/24/2024 at 8:34 AM, and 9/25/2024 at 9:08 AM. The resident stated their nails were too long, their hair had not been washed in 2 weeks, and they did not receive a shower on 9/24/2024. During an interview on 9/25/2024 at 11:13 AM, Certified Nurse Aide #25 stated showers were given twice a week and were documented in the bathing task. Bed baths were given in place of a shower if a resident requested. Hair washing was included in both showers and bed baths. If the shower task documentation stated yes then it meant a shower was given which included hair washing. Nail care was provided whenever needed and could be performed by aides if the resident was not a diabetic. Hair combing was completed every day. Any refusal of care was reported to the nurse. They gave Resident #15 a bed bath last evening at the resident's request but did not wash their hair because they received a bed bath and not a shower. They did not report to the nurse that hair washing was not completed. If residents did not receive their showers or have their hair washed it could cause that resident to feel uncomfortable, moody, or grumpy. Nail care was important because dirty nails could spread bacteria which could cause illness. During an interview on 9/25/2024 at 1:00 PM, Licensed Practical Nurse #6 stated residents received showers twice a week that included hair washing and nail care. Certified nurse aides should provide nail care anytime there was a need unless the resident was a brittle diabetic. Daily morning care should include hair combing. Any refusals of showers, nail care, or hair care should be reported to and documented by the nurse. Resident #15 usually received a shower or a bed bath. They had not noticed the resident's nails, but they should be clean and not jagged. No one had reported to them that Resident #15 refused any care. During an interview on 9/26/2024 at 10:08 AM, Licensed Practical Nurse Manager #22 stated they expected showers were given according to the shower schedule and included nail care and hair washing. If a bed bath was given, hair should still be washed. Nail care was done anytime they were long, jagged or debris was present, and hair combing was provided daily. Resident #15 required substantial assistance with hygiene care. If a shower was signed for by the aide, then it implied that hair was washed as well. During an interview on 9/26/2024 at 10:25 AM, the Assistant Director of Nursing stated showers were provided twice a week and were documented by the certified nurse aides in the electronic record. Personal care included nail care and should be offered daily. It was important to clean and clip nails whenever they were dirty or long to prevent cuts and infections. If nail care or hair care was needed, it should not wait until shower days to be provided. Residents should not have greasy hair and should be offered to have hair washed even if it was not their shower day. Not providing good hygiene could be a dignity and self-esteem issue. 10NYCRR 415.12(a)(3) 50561

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	335579	A. Building B. Wing	09/26/2024

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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 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. 48675 Based on observation, record review, and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 1 resident (Resident #178) reviewed. Specifically, Resident #178's urinary catheter (tube that drains urine) drainage bag was observed above the level of the bladder. Findings include: The facility policy, Urinary Catheter Guidelines, revised 9/11/2023, documented care was provided to residents with indwelling urinary catheters to prevent, reduce the reoccurrence, manage, and resolve urinary tract infections. The urinary catheter drainage bag should be positioned below the level of the bladder and should not touch the floor. Resident #178 had diagnoses including urinary tract infections and chronic kidney disease. The 9/19/2024 Minimum Data Set assessment documented the resident was cognitively intact, had an indwelling urinary catheter, and had a urinary tract infection within the last 30 days. The comprehensive care plan initiated on 9/14/2024 documented the resident had an indwelling urinary catheter. Interventions included maintaining the urinary drainage bag below the level of the bladder, monitor/record/report signs and symptoms of a urinary tract infection, change catheter as ordered, and urology consult as ordered. The 9/12/2024 physician orders documented: - Ciprofloxacin (antibiotic) 500 milligram, 1 tablet daily for 5 days for urinary tract infection. - Indwelling urinary catheter: size16 with a 5-milliliter balloon to down drain, change as needed. The following observations of Resident #178 were made: - on 9/24/2024 at 11:13 AM, 12:31 PM, and 12:43 PM sitting in their wheelchair in their room. Their urinary catheter tubing was observed coming out of the bottom of their left pant leg, under the wheelchair, and the drainage bag was clipped to the top of the wheelchair's backrest that was level with the resident's shoulders and above the bladder. At 12:59 PM, self-propelling their wheelchair down the hallway. The urinary catheter drainage bag was clipped to the bottom of the wheelchair. The resident stated one of the nurses approached them a few minutes ago, moved the drainage bag to the bottom of the wheelchair, and told them it should not have been put on the back of the wheelchair. (continued on next page)

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	335579	A. Building B. Wing	09/26/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 1:26 PM, Certified Nurse Aide #35 stated urinary catheter bags should always be clipped to the side of the bed or the bottom of a wheelchair. They stated the resident was self-propelling their wheelchair in the hallway when they noticed their catheter drainage bag was clipped to the top of the wheelchair's backrest. They moved it to the bottom of the wheelchair so the urine would be able to flow better. They stated catheter drainage bags should always be placed below the level of the bladder so the urine would not backup in the tubing and cause an infection. During an interview on 9/26/2024 at 9:17 AM, Licensed Practical Nurse #20 stated they noticed Resident #178's catheter drainage bag dragging on the floor under their wheelchair on 9/24/2024, so they moved it to the top of the wheelchair's backrest. They stated they forgot to move it back because they got busy, and by the time they remembered someone had already moved it to the bottom of the wheelchair. They stated it was important to keep catheter drainage bags below the level of the bladder to prevent backflow and urinary tract infections. During an interview on 9/26/2024 at 10:25 AM, Assistance Director of Nursing #3 stated urinary catheter drainage bags should be hung on the side of the bedframe or on the bottom of a wheelchair. They stated it was important for Resident #178's catheter drainage bag to be below the level of the bladder to prevent urinary tract infections. 10 NYCRR 415.12

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	335579	A. Building B. Wing	09/26/2024

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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. 50561 Based on observation, record review, and interviews during the recertification and abbreviated (NY00321293 and NY00321801) surveys conducted 9/23/2024-9/26/2024, the facility did not ensure each resident received adequate supervision for 1 of 2 residents (Resident #1) reviewed for falls. Specifically, Resident #1 was transferred without the use of a lift device as planned. The facility policy, Therapy Services, created 10/12/2021, documented therapy services would conduct a comprehensive patient centered evaluation which included the development of a plan of care with appropriate interventions to reach specified resident goals. The facility policy, Lift-Full Body Mechanical Lift, last reviewed 8/20/2023, documented at a minimum, two trained staff members were needed to safely move a resident with a floor based full body mechanical lift. Resident #1 had diagnoses included a left femur (thigh bone) fracture and frequent falls. The 8/2/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, was dependent on staff for all transfers, and had one fall. The comprehensive care plan initiated 7/7/2021 documented the resident required assistance with activities of daily living and was at risk for falls. Interventions included use of a sit to stand mechanical lift for all transfers. The 6/28/2024 Physical Therapist #12 Physical Therapy Discharge Summary documented the resident used the stand pivot disc for bed to wheelchair transfers. The Kardex (care instructions) documented the resident required a sit to stand mechanical lift for transfers. During an observation on 9/24/2024 at 2:00 PM Resident #1 was in their wheelchair in their room calling out for assistance. Certified Nurse Aide #24 stopped outside their door and asked the resident what they needed. When the resident stated they needed to be changed, Certified Nurse Aide #24 entered the room without any lift device and closed the door. At 2:06 PM, Certified Nurse Aide #24 exited room without a lift and the resident was lying in their bed. There was no lift device observed in the resident's room. During an observation on 9/25/2024 at 10:50 AM a lift device was not observed in Resident #1's room. Resident #1's visitor informed Licensed Practical Nurse #6 the resident was sitting in their wheelchair and needed to be changed. Licensed Practical Nurse #6 asked for the assistance of a certified nurse aide. Both Licensed Practical Nurse #6 and the certified nurse aide entered the room without a lift device. At 10:57 AM, Licensed Practical Nurse #6 brought the resident out of their room in their wheelchair followed by the certified nurse aide. Neither brought a lift device out of the room and there was not one observed in the resident's room. (continued on next page)

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	335579	A. Building B. Wing	09/26/2024

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/25/2024 at 12:52 PM, a visitor returned Resident #1 to their room in their wheelchair. At 1:30 PM the resident's family requested the resident be changed. Certified Nurse Aide #15 entered the resident's room without a lift device. The resident was in bed, Certified Nurse Aide #15 was in the bathroom, and there was no lift device in the room. During an interview on 9/24/2024 at 2:27 PM, Certified Nurse Aide #24 stated the transfer status of a resident was found in the computer kiosk and was checked every shift before they started working. A mechanical lift transfer always required the assistance of two staff for safety of the residents and to prevent falls. One person was needed to hold the lift and the other to hold the resident. Staff should only transfer residents according to what was documented on their care instructions. Resident #1 was independent with transfers a couple months ago, but after a fall and a broken hip they were changed to assist of 1 for transfers. During an interview on 9/25/2024 at 10:20AM, Resident #1 stated staff did not use a lift device to transfer them in and out of bed but used the resident's arms to transfer. During an interview on 9/25/2024 at 1:00 PM, Licensed Practical Nurse #6 stated resident's transfer status was documented in the care plan and on the task list. Therapy determined the transfer status of the residents. Transfer status was checked every day for changes and should always be followed. If a recommendation was for a sit to stand, it would not be appropriate to transfer a resident without the use of it. The facility had Hoyer lifts (a brand of a mechanical lift) and a mechanical sit to stand. The use of any lifting device required the assistance of two people. Resident #1 required assistance of two to stand pivot transfer, but a lift could be used if the resident was having difficulty. It was important that therapy's transfer recommendations were followed as the resident and staff could get hurt. During an interview on 9/25/2024 at 3:13 PM, Licensed Practical Nurse Manager #22 stated therapy determined a resident's transfer status. Those recommendations were communicated to nursing, who then updated the care tasks and care instructions. They expected the nurse aides to check the care instructions every time prior to the start of their shift. The facility had a Hoyer and a stand pivot disc, but not a mechanical sit to stand. All three devices required the assistance of two when used. Staff was allowed to use more assistance than required in the care plan, however, could not use less assistance than was documented in the care plan. Resident #1's therapy recommendation from 4/19/2024, indicated the resident required the use of a mechanical sit to stand lift. There was a handwritten notation to use stand pivot disc for transfers. Staff should use the stand pivot disk when transferring the resident. If therapy recommendations were not followed a resident could be injured. During an interview on 9/26/2024 at 9:14 AM, Physical Therapist #23 stated the facility currently used Hoyer lifts and a stand pivot disc. There was a mechanical sit to stand that was not functioning and had been in the basement for about six months. The mechanical sit to stand provided more assistance to the resident than the stand pivot disc. The stand pivot disk could be used on the unit by the certified nurse aides and required the assistance of 1 or 2 people and a gait belt. Physical therapy's transfer recommendations should be followed to provide consistency and to prevent falls or injuries. Resident #1 once used a four wheeled walker, but after a fall, therapy's recommendation changed to stand pivot disc with gait belt assistance of two. There had been no recent changes in the resident's status that had been reported to them and it was not safe to transfer the resident with assistance of one. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335579	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Center for Rehabilitation and Nursing	1045 West Street Carthage, NY 13619

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 11:42 AM, the Director of Nursing stated transfer status was in the care plan and care instructions and should always be followed unless changed by therapy. The facility had Hoyer lifts and a stand pivot disk and staff were educated on their use. There was not a mechanical stand lift in the building. The stand pivot disk required assistance of two and provided less support than the mechanical sit to stand. The two were not interchangeable. Resident #1's had a history of falls and their care task stated they were a mechanical lift sit to stand however, the clarified instructions documented a stand pivot disc. They expected staff to verify this because the mechanical sit to stand lift was not available. If the resident was care planned for a lift device, staff should be using it. It was not okay to transfer the resident with assistance of one or without the recommended device as falls, shoulder injuries, and staff injuries could occur. 10 NYCRR 415.12(h)(1)(2)