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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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 49448 Based on observation, record review, and interview during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure the discharge needs of each resident were identified and resulted in the development of a discharge plan for 1 of 1 resident (Resident #54) reviewed. Specifically, Resident #54 expressed the intention to be discharged to an assisted living facility and was not assisted with discharge planning or updated on the status of their discharge plan. Findings include: The facility policy, Discharge-Planning, revised 12/2019, documented the discharge planning process ensured residents had a discharge plan of continuing care that met their post-discharge needs and a goal of a safe and successful transition to the community, a lower level of care, or alternate healthcare facility. The Social Worker was responsible for the duties of Discharge Coordinator. The Discharge Coordinator developed a discharge plan that began on admission for each resident, initiated all necessary referral for post discharge care and needs, and documented the steps taken for discharge planning in the resident's medical record. Resident #54 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (lung disease), respiratory failure, and dependence on supplemental oxygen. The 7/8/2024 Minimum Data Set assessment documented the resident was cognitively intact, had no behavioral symptoms, required supervision or set-up assistance with most activities of daily living, was independent with transfers and ambulation, and active discharge planning was not occurring. The comprehensive care plan initiated 7/28/2024 documented the resident's placement was long-term care and the resident did not wish to be asked about returning to the community on all assessments. Interventions included participation in social/ recreational activities to promote well-being and support and encouragement were provided. The 4/26/2024 Physical Therapist #12 discharge progress note documented the resident had reached their goals upon discharge. The discharge recommendations were assistance with instrumental activities of daily living (preparing meals, managing medications, cleaning, getting around with transportation and managing money). The 4/26/2024 Occupational Therapist #13 discharge progress note documented the resident had reached maximum potential with skilled services and made consistent progress with skilled interventions. The 6/4/2024 Director of Social Work Social Services Assessment documented the resident was responsible for themself, and their goal was to be discharged to another facility/ institution. The resident was readmitted to the facility, and they were to remain long-term care and work on their well-being. There was no documented evidence the Director of Social Work discussed discharge goals and the need for long-term placement with the resident. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's Notice of Medicare Non-Coverage documented Medicare covered Skilled Nursing Facility Services would end on 6/20/2024. The resident signed the notice on 6/18/2024. The 8/5/2024 Psychiatric Mental Health Nurse Practitioner #10 progress note documented the resident reported they were waiting for assisted living placement. The 8/6/2024 Physician #9 progress note documented the resident was at their treatment and care plan goals and was to be discharged to assisted living if possible. The 8/24/2024 Psychiatric Mental Health Nurse Practitioner #10 progress note documented the resident reported that they continued to wait for assisted living placement. There was no documented evidence the possibility of discharge to an assisted living facility was discussed with the resident or if referrals were made. During an interview on 9/23/2024 at 10:08 AM, the resident stated they were trying to find somewhere else to live. During an interview on 9/25/2024 at 8:58 AM, the resident stated they went out with family yesterday. They went shopping, out to eat, and got a new cellular phone. Their social worker was supposed to be helping them get to an assisted living facility for the past 4-6 months. They asked their social worker every day, and their social worker told them they had not heard anything. When they talked to their social worker a couple of days ago, the social worker said they were going to call some facilities. They did not know if they had made any calls yet or to what facilities. They wanted to move closer to where they lived prior to coming to the facility. During an interview on 9/25/2024 at 12:59 PM, Certified Nurse Aide #15 stated the Director of Social Work was responsible for and assisted residents with discharge planning. Resident #54 did not need any assistance from the certified nurse aides. The resident bathed, brushed their teeth, washed their face, and dressed themselves independently. They thought the resident could probably live in an assisted living facility. During an interview on 9/25/2024 at 1:29 PM, Licensed Practical Nurse #14 stated the resident was independent with activities of daily living. It was important the resident went to a lower level of care to facilitate independence and it would be beneficial for mood and lifestyle. The resident spent their days either in their room or the dining room and if they were at an assisted living facility, they could go for a walk or do many different things. The Director of Social Work was responsible for assisting residents with discharges. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 1:54 PM, the Director of Social Work stated the discharge process started on their first visit within 3 days of admission. They were the only social worker for the facility. Prior to discharge the resident had to be cleared by the physician, medical staff, and therapy. If a resident was appropriate to be discharged to assisted living, they sent out referral packets via facsimile. They then waited for call backs and followed up periodically if they had not heard anything back. When Resident #54 was discharged from therapy, discharge to assisted living was discussed. The resident wanted to go somewhere close to where they lived before, but they were not familiar with the facilities in that area. They stated the resident would do great in an assisted living setting. For the past 2 weeks the resident came to their office every morning and asked about moving to an assisted living facility and they told the resident they had not forgotten about them and that the process took time. It was important that progress of the process was communicated with the resident. They could not remember how long it was since the resident first approached them about moving to an assisted living facility but at that time there were long wait lists. They had not yet sent out any referral packets for Resident #54. The resident's family came to them today and asked about a transfer to another facility as well. 10NYCRR 415.11(d)(3)

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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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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)

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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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48446 49448 Based on observation, record review, and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standard of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 2 of 2 residents (Residents #66 and #369) reviewed. Specifically, Resident #66 developed three facility acquired pressure ulcers, one vascular wound (caused by poor blood circulation) and had a low loss air mattress (specialty mattress used to relieve pressure and provide airflow) that was not accurately set to the resident's weight, and the resident was not turned and repositioned as care planned. Resident #379 had a foot wound and did not have their foot offloaded as planned. Findings include: The facility policy, Support Surfaces- Air mattress, created 2/2019, documented the facility provided an environment of care that promoted the highest quality of care and comfort for the residents. This included the treatment and prevention of pressure ulcers with the use of support surfaces. The motor was set to the appropriate settings per the resident assessment. For example, weight for weight. Depending on mattress type, a turning and repositioning schedule was determined. The facility policy, Skin and Pressure Injury Prevention, revised 6/27/2024, documented the facility assessed residents for risk in the development of pressure injuries and implemented preventative measures in accordance with current standards of practice. Once the assessment was conducted and risk factors were identified and characterized, a resident-centered care plan was developed and addressed the modifiable risks for pressure injuries and skin protection interventions. For a person in bed, position was changed frequently, and a pressure relieving/ redistribution device was on the bed. When in bed, every attempt was made to off load pressure to heels and interventions included placement of pillows, heel boots, or other devices as recommended by provider. 1) Resident #66 had diagnoses including hemiplegia and hemiparesis (weakness or paralysis of one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, osteomyelitis (bone infection) of the sacrococcygeal (tailbone) region, and severe protein-calorie malnutrition. The 9/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, had upper extremity impairment on one side, lower extremity impairment on both sides, was dependent for assistance with toileting, bathing, dressing, bed mobility, and transfers, was at risk for developing pressure ulcers, had 4 unstageable (full thickness, depth unknown) pressure ulcers that were not present on admission, received daily pressure ulcer care, applications of ointments/ medications other than to feet, had a pressure relieving device for the bed, and did not reject care. The Comprehensive Care Plan initiated 4/26/2024 documented the resident had alteration in skin integrity with an actual unstageable pressure injury to the sacrum and left buttocks and a vascular wound to the left lower extremity. Interventions included weekly wound evaluations, dressings were monitored to ensure they were clean, dry, and intact, and the wound was monitored for changes and signs/ symptoms of infection. There were no documented interventions for pressure relief. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated care instructions documented the resident was provided with a pressure relieving/ redistribution device on the bed and the resident was dependent on one to turn and reposition every 1-2 hours as indicated and as needed. The 8/20/2024 physician orders documented low loss air mattress: check setting closest to resident's current weight and mattress functionality every shift. The 9/18/2024 Nurse Practitioner #38 progress note documented the resident was being seen as requested by nursing to evaluate their wounds. The left posterior leg vascular wound measured 5.0 centimeters x 3.2 centimeters with a pink base. The sacrum wound with undermining measured 12.1 centimeters x 10 centimeter x 4 centimeters. The new unstageable left buttocks ulcer measured 1.2 centimeters x 1.1 centimeters with 100 percent yellow base. There was also a left buttock skin abrasion, no measurements were documented. Interventions included continued use of an air mattress and signs and symptoms of wound infection were monitored. Pressure ulcers were unavoidable as the resident was comfort care, bed bound, and had poor nutrition. The 9/25/2024 Registered Nurse #39 weekly wound evaluation documented the wounds were evaluated by the wound care provider and refer to the wound care provider documentation. Interventions included turning and repositioning, heels off loaded with pillow or heel boots, and pressure relieving/ reducing device on bed. The 9/25/2024 Nurse Practitioner #38 progress note documented the resident was being seen as requested by nursing to evaluate their wounds. The left posterior leg vascular wound measured 5.3 centimeters x 3 centimeters with a pink base. The sacrum wound with undermining measured 9 centimeters x 10.4 centimeters x 2 centimeters with 2 centimeter undermining at 7 o'clock. The unstageable left buttocks ulcer measured 0.5 centimeters x 1.1 centimeters with 100 percent yellow base. The left buttock skin abrasion measured 1 centimeter x 1 centimeter. Pressure ulcers were unavoidable as the resident was comfort care, bed bound, and had poor nutrition. The September 2024 Certified Nurse Aide activities of daily living tasks did not document the resident was turned and repositioned during their shift on 9/1/2024 day shift, 9/4/2024 night shift, 9/5/2024 day shift, 9/15/2024 night shift, 9/17/2024 day shift, and 9/18/2024 night shift. The resident's medical record contained no documentation for the appropriate settings for the pressure relieving air mattress. The Weights and Vital Summary Report documented the resident was not weighed on 9/4/2024 comfort measures-no weights. The last documented weight was 123 pounds on 8/14/2024. Resident #66 was observed; - On 9/23/2024 at 10:29 AM, 12:19 PM, and 2:08 PM, lying in bed with the low air loss mattress set to 380 pounds with the mattress pump upside down on the floor under the bed. - On 9/24/2024 during a continuous observation from 9:07 AM until 11:11 AM, lying in bed with the low air loss air mattress set to 380 pounds with the pump upside down on the floor under the bed. At 1:03 PM the low air loss mattress was set to 230 pounds. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 9/25/2024 at 9:07 AM, lying in bed with the low air loss mattress set to 230 pounds, the pump was on the foot end of the bed with a pillow over it. At 12:03 PM, 1:19 PM, and 3:28 PM, lying in bed with the low air loss mattress set to 230 pounds and signed as checked by Licensed Practical Nurse #14. - On 9/26/2024 at 9:25 AM, sleeping in bed on their back with the low air loss mattress set to 230 pounds with the pump on the foot end of the bed. During an interview on 9/25/2024 at 1:03 PM, Certified Nurse Aide #15 stated the care instructions told them the frequency a resident needed to be turned and repositioned. The documentation did not include the frequency of turning and repositioning, just that it was completed on their shift. If there was a refusal, it would be documented as a refusal. Turning and repositioning meant they rotated what side the resident was lying on and was important for skin breakdown and discomfort. Resident #66 had wounds and it was important they were repositioned every 2 hours. The air mattress was set by the nurse per the resident's weight. During an interview on 9/26/2024 at 9:27 AM, Certified Nurse Aide #41 stated residents were turned and repositioned every few hours. This meant the resident was in different positions for wound prevention, to keep off pressure points or for wound improvement if wounds were already present. Turning and repositioning meant residents were rotated from side to back and then to the other side. Resident #66 was supposed to be repositioned every 2 hours as they had wounds. They tried to reposition the resident as often as possible, but it was often difficult due to staffing shortages so they just did the best they could. The air mattress was set to the resident's weight but as a certified nurse aide, they did not touch or even look at the settings. They reported it to the nurse if the mattress was not inflated or they noticed a problem with it. During an interview on 9/26/2024 at 9:35 AM, Licensed Practical Nurse #28 stated air mattresses were set to the weight of the resident. The setting was checked at least once per shift. They did not think it was documented anywhere. Documentation meant the settings were checked. If a resident was no longer being weighed, they would not know what the mattress should be set to. They just pushed down on Resident #66's mattress and adjusted the dial per their feeling of too soft or too hard. Resident #66 was tiny, 300 pounds was probably too hard for them, and they were not sure if the mattress set inappropriately could lead to worsening pressure. They thought if the air mattress was set to the resident's weight it would be too soft. They adjusted the setting to 180 pounds a couple days ago by going with their gut. The pump was currently set at 210ish, was missing clips to hang it on the bed frame, and it should not be in the resident's bed. They did not think the weight setting was important, just what the mattress felt like to touch. The low-pressure light was blinking so they would have to have maintenance look at it. They confirmed the air mattress was documented in the Treatment Administration record but just that the air mattress existed, not what setting they set it to. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 10:19 AM, Licensed Practical Nurse Unit Manager #22 stated turning and repositioning meant the resident was rotated from left side to right or to their back. The purpose was to prevent skin breakdown or worsening breakdown. It was documented per shift and if it was documented, it was expected it was done at the frequency indicated on the care instructions. If a resident had an air mattress, they needed an order for it and part of the order was the setting and to check functionality. If the air mattress was not set to the resident's weight it should be fixed. Resident #66 was comfort measures only and it should be set closest to the weight last documented. Nurses should not be self-selecting settings based upon whether they thought the mattress was too hard or too soft. The resident's last documented weight was 123 pounds on 8/14/2024 and their air mattress set at 380 pounds could make their pressure worse. During an interview on 9/26/2024 at 11:28 AM, the Assistant Director of Nursing stated the certified nurse aides documented turning and repositioning every shift, not every occurrence. There was no way of knowing if the resident was turned and repositioned as care planned because there was no way to document it. It was also not known when the next turn and reposition was due. It was important for frequent turning and repositioning for wound healing and could make the wound worse if not done. Air mattresses were set to the resident's closest weight. It was important it was set appropriately so the resident did not sink into the mattress, or the mattress was not too hard. It was documented by the nurses in the Treatment Administration Record every shift. If it was documented, it meant the settings were verified and if it was not documented, it was not checked. Resident #66 had pressure sores and should be turned and repositioned. The resident's last documented weight was 123 pounds and if their air mattress was set to 380 pounds it would not help with wound healing, they would be on a very hard surface. Nurses were expected to follow orders, they had recently done a training on air mattresses. Nurses were expected to look at the dial and adjust accordingly, pushing on the air mattress was not an appropriate way to set the dial. Resident #66 would not be on their back all day if they were appropriately turned and repositioned. 2) Resident #379 had diagnoses including spinal stenosis (narrowing of the spinal canal), diabetes, and osteomyelitis of the left foot and ankle (bone infection). The Minimum Data Set assessment was not yet completed as the resident was a new admission. The 9/20/2024 at 7:16 PM Registered Nurse #39 Nursing Admission Evaluation documented the resident was admitted to the facility for osteomyelitis of the left foot. The Comprehensive Care Plan dated 9/21/2024 documented Resident #379 was at risk for skin breakdown due to obesity and disease processes. Interventions included skin observations, compression dressing was applied, and adaptive equipment was removed when skin integrity was checked. The undated care instructions documented Resident #379's heels were offloaded with heel boots as tolerated. Resident #379 was observed on 9/24/2024: - at 9:19 AM with a heel bootie hanging from the left side of the bed and their foot resting directly on the bed, the left foot was not offloaded. - at 11:27 AM in bed and the left foot was not offloaded. The boot was on the floor at the end of the bed. The resident stated they wore the boots at home and they made their foot more comfortable. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 2:43 PM in bed with the boot on the left foot with the foot dangled over the footboard which applied pressure to the left foot. The Certified Nurse Aide Documentation Survey Report documented heel protection: offload with pillow/heel boots/heel suspension boots as tolerated and was completed every shift on 9/24/2024 and 9/25/2024. During an interview on 9/25/2024 at 8:40 AM, Certified Nurse Aide #37 stated Resident #379 came into the facility with a heel boot because they had a wound on their left foot and continued with the heel boot after admission. The heel boot was old, worn, and dirty so they received a new one from physical therapy after admission. If they did not have the heel boot on, the wound could get worse. During an interview on 9/25/2024 at 12:29 PM, Licensed Practical Nurse #31 stated offloading boots removed pressure from areas, prevented wounds from worsening, and provided comfort. They stated Resident #379 was supposed to wear an offloading heel boot to the left foot when they were in bed as they had a wound and required staff assistance to apply the boot. During an interview on 9/25/2024 at 12:53 PM, Licensed Practical Nurse Unit Manager #32 stated care plans were individualized for each resident and completed by a registered nurse on admission. They stated offloading boots were documented on the certified nurse aide instructions. They stated an offloading boot did not require a physician order and could be applied by any nursing staff. They stated if the offloading boot was not worn, the resident could have increased pain and decreased wound healing and Resident #379 had a significant wound. They expected the boot to be on at all times unless the resident refused. Resident #379 did not refuse the boot. During an interview on 9/26/2024 at 10:54 AM, the Assistant Director of Nursing #3 stated care plans were individualized for each resident and ensured the care needs for each resident were met. They did not expect heel boots to be hanging over the bed or on the floor. If the boot was not worn the resident could have decreased healing to a wound or a worsening wound. They stated Resident #379 utilized an offloading left heel boot. 10NYCRR 415.12(c)(1)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50561 Based on observation, record review, and interviews, during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for 2 of 2 residents (Resident #7 and #15) reviewed. Specifically, Residents #15 and #7 resting palm (hand) guards were not applied appropriately as recommended by occupational therapy for hand and finger contractures (shortening of muscle or tendons preventing normal movement). Findings include: The facility policy, Appliances- Splints, Braces, Slings, revised 4/2019 documented to protect the safety and well-being of residents, and to promote quality care, the facility used appropriate techniques and devices for appliances, splints, braces, and slings; nursing would ensure certified nurse aide staff knew the proper application and removal of appliances; and nursing would ensure the appropriate sign off of appliance task options. 1) Resident #15 had diagnoses including dementia, weakness, and need for assistance with personal care. The 6/30/2024 Minimum Data Set documented the resident had impaired cognition, functional limitation of the upper extremity, did not refuse care, and required maximum assistance for most activities of daily living. The Comprehensive Care Plan initiated 3/4/2021 documented the resident had limited physical mobility related to gait and mobility abnormalities. Interventions included a left palm protector on at all times except during functional tasks. The resident's Kardex (care instructions) documented left palm protector on at all times except for functional tasks. The 7/30/2024 Occupational Therapy Evaluation and Plan of Treatment by Occupational Therapist #13 documented Resident #15 had a left-hand contracture and during prior therapy sessions from 6/12/2024-7/3/2024 the resident received services to decrease the contracture in their left hand that included a palm protector splint. The resident was observed in their room without a left palm protector on 9/23/2024 at 11:14 AM, 9/24/2024 at 8:34 AM, 9/24/2024 at 12:48 PM, and 9/25/2024 at 9:08 AM. During an interview on 9/25/2024 at 11:13 AM, Certified Nurse Aide #25 stated certified nurse aides applied splints and documented in the task section of the electronic record. If splints were missing or the resident refused, it was reported to the nurse. Resident #15's resident care instructions listed a left palm guard at all times but was not listed as a task they could sign off on. Splints were important to prevent contractures. If a splint or guard was recommended but not used, the resident's contractures could worsen. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/2024 at 1:00PM, Licensed Practical Nurse #6 stated certified nurse aides applied splints and if there was a problem applying them it should be reported to the nurse and documented. Splints required an order and were on the treatment administration record for signatures. They were not aware Resident #15 had a recommendation for palm guards. The 9/2024 Treatment Administration Record did not document the use of a palm protector splint. During an interview on 9/25/2024 at 3:13 PM, Licensed Practical Nurse Manager #22 stated therapy evaluated residents for contractures. If a splint was recommended, nursing was informed so the resident's care instructions and care plan could be updated and a task for the aides to document created. Certified nurse aides applied splints and palm guards and any issues or refusals were reported to the nurse and documented. Palm guards were used for hand contractures and should be worn as recommended. If not, open areas, worsening of contractures, and pain could occur. Resident #15 had contractures of their hands and should have a left palm guard on at all times except during functional tasks. This was listed on the resident's care instructions and as a task, however, the task did not allow the certified nurse aides to sign off on. During an interview on 9/26/2024 at 9:14 AM, Physical Therapist #23 stated the therapy department evaluated residents and when splints were recommended, they informed nursing so the care plan could be updated. They expected their recommendations to be implemented and any issues should be reported to them. Resident #15 had hand contractures and a hand guard was recommended. Palm guards were effective in maintaining current range of motion, keeping hands clean, and preventing skin integrity issues that could be caused by fingernails coming into contact with palms. During an interview on 9/26/2024 at 11:42 AM, the Director of Nursing stated therapy made recommendations for splints and palm guards and anyone who had a recommendation should have a task associated with the splints allowing the certified nurse aides to document in the electronic record. Any refusals should be reported to nursing to verify and document. Resident #15 had a left palm guard listed in their care instructions and as a task, however the task had not been activated properly resulting in the certified nurse aides being able to see the task, but not being able to document the task. They felt staff should have asked and verified whether the guards should be put on or not. If palm guards were not applied per recommendations contractures could worsen and skin breakdown could occur. 2) Resident #7 had diagnoses including dementia and Huntington's disease (a progressive neurological disease). The 7/17/2024 Minimum Data Set documented the resident had severe cognitive impairment, did not refuse care, had functional limitation in range of motion in both arms, and was dependent for most activities of daily living. The Comprehensive Care Plan initiated 4/26/2021 documented the resident had limited physical mobility related to deconditioning, Huntington's disease, and functional quadriplegia (inability to move arms and legs). Interventions included bilateral palm guards at all times except during hygiene care. The 10/16/2023 Occupational Therapy Evaluation and Plan of Treatment by Occupational Therapist #13 documented Resident #7 had impaired range of motion in the wrists, hands, and all fingers and recommended that finger separators and a [NAME] guard was worn on both hands at all times except during bathing and exercise. (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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/3/2023 Occupational Therapy Discharge Summary by Occupational Therapist #13 documented the resident's goal of maintaining tolerance for bilateral palm protectors 24 hours a day with periodic skin assessment was met on 10/27/2023. Resident #7's Kardex (care instructions) documented bilateral palm guards on at all times, remove for hygiene. Resident #7 was observed in their room without palm guards on their right and left hands on 9/23/2024 at 11:08 AM, 9/24/2024 at 8:34 AM, and 9/24/2024 at 1:29 PM. During an interview on 9/25/2024 at 11:13AM, Certified Nurse Aide #25 stated Resident #7 had contractures but did not believe the resident wore splints because they had never seen the resident with them. The resident's care instructions included bilateral palm guard at all times but was not listed as a task for the aides to sign for. During an interview on 9/25/2024 at 1:00PM, Licensed Practical Nurse #6 stated they were not aware Resident #7 had a recommendation for palm guards. During an interview on 9/25/2024 at 3:13 PM, Licensed Practical Nurse Manager #22 stated Resident #7 was very stiff and had bilateral palm guards listed in their care plan, in their resident care instructions, and as a task. The task did not allow the certified nurse aides to document in the electronic record. During an interview on 9/26/2024 at 9:14 AM, Physical Therapist #23 stated Resident #7 had hand contractures and palm guards were recommended. The only compliance issue they were aware of occurred 3 months ago when the guards were reported missing and was resolved when they were found in the laundry. During an interview on 9/26/2024 at 11:42 AM, the Director of Nursing stated Resident #7 had hand contractures and bilateral palm guards listed in their care instructions and as a task, however the task had not been activated properly resulting in the certified nurse aides being able to see the task, but not being able to document the task. Staff should have asked and verified whether the guards should be put on or not. Residents that were ordered palm guards and did not wear them could have worsening of contractures and skin breakdown. 10NYCRR 415.12(e)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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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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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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

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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)

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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. 49448 Based on observation, record review, and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure that residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for 1 of 1 resident (Resident #17) reviewed. Specifically, Resident #17 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments. Additionally, staff documented the resident had an arteriovenous fistula (surgical connection between an artery and a vein often used for dialysis access) which the resident did not have. Findings include: The facility policy, Dialysis Access Care, revised 5/2019, documented the central catheter (a tube inserted into a large, central vein) site was kept clean and dry at all times and bathing and showering were not permitted with this device. Catheter lumens (outside ends of the catheter) were capped and clamped when not in use. The general medical nurse documented in the resident's medical record every shift the location of the catheter, condition of the dressing, if dialysis was done during the shift, and any report from dialysis nurse post-dialysis and observations post dialysis. The facility policy, Dialysis Management, revised 5/2019, documented residents that received hemodialysis treatments were assessed and monitored and ensured quality of life and well-being. The access site was observed for function and signs and symptoms of infection. Orders were obtained for monitoring of the site and interventions as appropriate. Permacaths (a central catheter used for long-term access) were observed for bleeding and placement. The nurse would evaluate the resident post dialysis for access site condition and document in the nurse's notes. Resident #17 had diagnoses including end stage renal (kidney) disease, dependence on renal dialysis, and cerebral infarction (stroke). The 7/19/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, did not reject care, had end stage renal disease, and required hemodialysis treatments. The Comprehensive Care Plan initiated 5/22/2024 documented the resident needed hemodialysis related to end stage renal disease. Interventions included the check the access site dressing daily; change dressing only if ordered by the physician; document condition and complications; monitor for signs of infection such as redness, swelling, warmth, or drainage and document; and monitor the Permacath to the right upper chest for bleeding and placement. The resident received dialysis on Monday, Wednesday, and Friday with a 6:00 AM pick up time and a 7:00 AM chair time. The 8/12/2024 physician order documented monitor the Permacath for bleeding and placement every shift. If bleeding was noted, pressure was to be applied, and the physician was to be notified. If dislodged, pressure was applied and 911 was to be called. The order did not specify the location of the Permacath. The dialysis communication book documented the resident attended dialysis on 9/2/2024, 9/4/2024, 9/6/2024, 9/9/2024, 9/11/2024, 9/13/2024, 9/16/2024, 9/18/2024, 9/20/2024, 9/23/2024 and 9/25/2024. (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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence of pre-dialysis evaluations on 9/2/2024, 9/13/2024, 9/18/2024, 9/20/2024, and 9/23/2024. There was no documented evidence of post-dialysis evaluations on 9/4/2024, 9/6/2024, 9/13/2024, and 9/20/2024. During an observation and interview on 9/23/2024 at 12:21 PM, Resident #17 stated they attended dialysis on Monday, Wednesday, and Friday at a community-based dialysis center and they had just gotten back. The resident had a right chest dual lumen Permacath for dialysis covered with a white dressing that was clean, dry, and intact. They did not recall if the facility obtained vital signs or weights before or after dialysis treatments. There was a binder that went with them back and forth from dialysis. The 9/23/2024 Licensed Practical Nurse #28 post dialysis evaluation documented the resident had a Permacath and their arteriovenous fistula bruit (swooshing sound that indicates the fistula is working) was audible, and thrill (a vibration that can be felt when placing fingers over the arteriovenous fistula indicating blood flow) was present. No site changes of the arteriovenous fistula. There was no documented evidence in the resident's medical record of an arteriovenous fistula. The 9/25/2024 Licensed Practical Nurse #14 post dialysis evaluation documented the resident had a Permacath and the arteriovenous bruit was audible, and thrill was present. No site changes of the arteriovenous fistula. During an interview on 9/25/2024 at 1:35 PM, Licensed Practical Nurse #14 stated pre and post dialysis assessments were documented electronically. Resident #17 had a Permacath, but they did not remember where their access site was located. They had completed the resident's post dialysis assessment today around 11:30 AM when the resident returned from dialysis. They looked at the access site with that assessment. They checked the electronic medical record and confirmed they completed the post dialysis assessment at 11:37 AM but was not sure where the access site was located. It was important the site was monitored because the resident could bleed out. During an interview on 9/25/2024 at 3:29 PM, Licensed Practical Nurse #28 stated Resident #17 had a Permacath to their left chest for dialysis. The dressing was supposed to be clean, dry, intact and without signs of infection. They were not sure if the site should be monitored for anything else. The pre and post dialysis assessments were documented and if they were not documented, they were not done. During a follow up interview on 9/26/2024 at 9:46 AM, Licensed Practical Nurse #28 stated the resident had a right chest Permacath only and did not have an arteriovenous fistula. They showed the surveyor the electronic charting of the post dialysis note. They documented on an arteriovenous fistula because not applicable was not an option. It was not appropriate to document on an arteriovenous fistula because Resident #17 did not have one. (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 interview on 9/26/2024 at 10:35 AM, Licensed Practical Nurse Unit Manager #22 stated pre and post dialysis assessments were completed and contained information about the site appearance and type of access site. An arteriovenous fistula should not be documented if the resident did not have that type of access site. It was important the site was monitored for bleeding and signs of infection. It was also monitored every shift and documented in the Treatment Administration Record and if it was documented, it meant the nurse looked at the site. Resident #17 received dialysis and the site should be monitored. During an interview on 9/26/2024 at 11:18 AM, the Assistant Director of Nursing stated the pre-dialysis assessment documented either a Permacath access site or an arteriovenous fistula. The nursing staff checked the dialysis site for bleeding, if the Permacath was intact, and not pulled out. If it was not documented, it was not done. The site was monitored every shift for displacement, bleeding, and signs of infection. If the site was monitored staff should know where the site was located. Resident #17 received dialysis and had a right chest Permacath. They checked the resident's electronic medical record and the pre and post dialysis assessments were not being consistently done but should have been. It was especially important the site was monitored after dialysis because there could be a medical emergency. It was important that any changes to the site appearance or the resident's vital signs were communicated to dialysis and without the appropriate assessments, changes were not monitored. 10NYCRR 415.12(k)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 33421 48446 48675 Based on observation and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 3 of 3 meals (the 9/24/2024 lunch meal, the 9/25/2024 special Fall festival meal, and the 9/25/2024 lunch meal) reviewed; for 7 of 7 anonymous residents present at the Resident Council meeting; and for 2 additional residents interviewed (Residents #178 and #180). Specifically, the 9/24/2024 and 9/25/2024 lunch meals were not flavorful; the 9/25/2024 Fall festival meal was not served at palatable and appetizing temperatures; 7 of 7 anonymous residents at the Resident Council meeting stated the food was often not appetizing and served cold; and 2 residents (Resident #178 and #180) stated the food was not flavorful and was served cold. Findings include: The facility policy, Rapid Cooling of Food, revised 1/2023, documented temperature control for food safety would be maintained at a temperature greater than 135 degrees Fahrenheit or cooled to a temperature of 40 degrees Fahrenheit. During an interview on 9/23/2024 at 11:25 AM, Resident #178 stated the food was bland, did not taste good, and was served cold. During an interview on 9/23/2024 at 11:42 AM, Resident #180 stated the food had an unpleasant taste and texture and was usually served cold. During a resident group interview on 9/23/2024 at 1:32 PM, 7 anonymous residents stated the food did not taste good and was not served hot. During an interview on 9/24/2024 at 9:40 AM, Certified Nurse Aide #30 stated residents complained the food did not taste good and was not served hot. During a lunch meal observation in the main dining room on 9/24/2024 at 12:04 PM, a lunch meal tray was tested . The beef stroganoff was measured at 135 degrees Fahrenheit, and the beef tasted bland and was difficult to chew due to a rubbery texture. During a Fall festival lunch meal observation in the main dining room on 9/25/2024 at 12:08 PM, a lunch meal was tested . The corn dog was measured at 100 degrees Fahrenheit, the sweet potato fries were measured at 99 degrees Fahrenheit, and the corn on the cob was bland, chewy, and mushy. During a lunch meal observation on 9/25/2024 at 12:32 PM, Resident #72's meal tray was tested , and a replacement tray was ordered. The barbeque chicken was bland, and the barbeque sauce tasted like plain ketchup. The corn on the cob was bland, chewy, and mushy. (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/26/2024 at 9:27 AM, Activities Aide #42 stated there was miscommunication during the Fall festival meal regarding who was supposed to take the temperatures of the food that was being served. The activities department obtained the food from the kitchen, and they served it to the residents. They stated they should have taken the temperature of the food that was being served even though they used a portable stove to keep the food hot. During an interview on 9/26/2024 at 9:46 AM, the Food Service Director stated the activities and dietary department cooked the food for the Fall festival. The cook should have taken temperatures of the food but there was miscommunication between the departments, they were short staffed, and the cook was doing other jobs and not just cooking. They were unsure when the last test tray was done. The registered dietitian used to do test trays, but they were working remotely so the test trays were not being done regularly. They stated they planned to start doing them again. They usually tasted the food while it was being cooked. The cooks had recipes to follow and were not able to add salt, but used spices like garlic and pepper, and they would add salt and pepper on resident trays if they were allowed to have it. The corn dogs and sweet potato fries were not hot enough and should have been served at a minimum of 140 degrees Fahrenheit and the food served to the residents should always be palatable. During an interview on 9/26/2024 at 10:13 AM, the Director of Activities stated the food for the Fall festival was reheated using a portable stove after it was cooked. The cook took the food temperatures when it came out of the oven and told them the temperatures were okay. They were unsure what temperature the food should have been kept at and normally the kitchen staff would have helped, but they were short staffed. 10NYCRR 415.14(d)(1)(2)

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

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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. 48446 Based on observation, record review, and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 1 of 1 resident (Resident #383) reviewed. Specifically, Resident #383 had a physician order for a nectar thick consistency for all liquids and was served thin liquids. Findings include: The facility policy, Modified Food Consistency Policy, reviewed 2/2023, documented diets were individualized with modifications made by the speech/language pathologist and physician in conjunction with the registered dietitian or designee and Director of Food Services. A written order was required. The food and nutritional services department was responsible for preparing and serving the diet texture and fluid consistency as ordered. The facility diet manual documented nectar thick liquids consistency was syrup like and coated a spoon. Resident #383 had diagnosis of Parkinson's disease (a progressive neurological disease) and dysphagia (difficulty swallowing). The resident was admitted during the evening on 9/23/2024. The 9/23/2024 hospital discharge summary documented Resident #383 was evaluated by a speech language pathologist for ongoing dysphagia which was present prior to admission. The resident was mostly nonverbal at baseline secondary to Parkinson's disease and a traumatic subdural hematoma (collection of blood between the brain and skull) following a fall in February 2024. The resident underwent a modified barium swallow study (evaluates swallowing ability) on 9/23/2024 which showed moderately severe oropharyngeal dysphagia consistent with Parkinson's disease. Their swallow was severely delayed, and their pharyngeal musculature was very weak. It was recommended to continue a pureed and nectar thick diet. The physician #9 9/23/2024 admission orders documented a heart healthy puree texture and nectar thick consistency diet. During an observation on 9/24/2024 at 8:24 AM, Resident #383 was in their room in bed with their breakfast tray. Their family member asked Physical Therapist #17 who was in the hall, why Resident #383 had thin liquids when they had nectar thick liquids in the hospital until their discharge yesterday evening. Physical Therapist #17 stated they would look into it and get back to the family member. The meal ticket documented a pureed diet only. There was no documentation of nectar thick liquids. Physical Therapist #17 returned and stated they checked with the nurse and Resident #383 was ordered nectar thick liquids and they removed all the thin liquids from the resident's tray before the resident drank. The resident's breakfast meal ticket dated 9/24/2024 documented nectar thick orange juice, nectar thick skim milk, nectar thick coffee, and nectar thick water. (continued on next page)

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/2024 at 8:56 AM, Resident #383's family member stated the resident was in the hospital following a tractor rollover, they were recovering from multiple broken bones, and they underwent a swallowing evaluation before being admitted to the facility. After the swallowing evaluation the family member was told Resident #383 was silently aspirating (inhaling food or liquids in the lungs). They visited the resident last evening after dinner was served and did not observe the meal served to the resident. During an interview on 9/24/2024 at 9:40 AM, Certified Nurse Aide #30 stated the wrong tray was given to Resident #383 that morning. During an interview on 9/25/2024 at 12:29 PM, Licensed Practical Nurse #31 stated when there was a new admission, orders were sent from the hospital to the facility for review and the orders were entered before the resident arrived. Orders were entered by the admitting licensed practical nurse which included diet orders. After the diet was ordered they thought the order went to the kitchen and the registered dietitian, and the meal ticket was printed by the front desk attendant and given to the kitchen staff. During an interview on 9/25/2024 at 12:53 PM, Licensed Practical Nurse Unit Manager #32 stated they were notified of the pending admissions every morning. The hospital called report to the unit nurse and the admission assessment was completed by them or the unit licensed practical nurse and a diet was ordered. Director of Food Services #33 picked up the diet order and ensured each resident received the correct diet. They stated Resident #383 arrived at the facility on 9/23/2024 at approximately 5:00 PM and was ordered a pureed nectar thick diet because they had swallowing problems at the hospital. They were unsure what diet consistency Resident #383 received for dinner on 9/23/202 or how the resident received the wrong fluid consistency for breakfast on 9/24/2024. They stated it was important for the resident to get the right consistency because they could choke and get pneumonia. During an interview on 9/25/2024 at 3:16 PM, Physical Therapist #17 stated they were working in the morning on 9/24/2024 when they were notified by a family member that Resident #383 had the wrong fluid consistency on their tray. They looked at the meal ticket which documented regular pureed. If the resident was on nectar thick liquids the meal ticket would document puree/nectar, however the ticket did not document nectar thick liquids. They asked Licensed Practical Nurse #14 who confirmed the resident was ordered nectar thick liquids. Physical Therapist #17 stated they removed all the thin liquids which included coffee, orange juice, and milk from the resident's tray. They stated if a resident received the wrong consistency they could aspirate and get pneumonia. During an interview on 9/26/2024 at 9:30 AM, Food Service Director #33 stated they were notified of new admissions during their morning meeting. After residents arrived at the facility, they were notified by the receptionist in an email. They stated Resident #383 arrived at the facility at approximately 5:00 PM, and there was no diet order in the system, so they asked a nurse on the unit for the diet order. They were unsure what nursed told them the resident was on a pureed diet. They stated the nurse did not tell them the resident was on nectar thick liquids, they did not ask, but they should have. They stated Resident #383 received thin liquids on their 9/23/2024 dinner tray and on their 9/24/2024 breakfast tray. They stated the resident could have choked if they consumed the wrong consistency liquids. (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

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

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 10:54 AM, Assistant Director of Nursing #3 stated nurses were responsible for checking the meal ticket to ensure the resident had the correct consistency. They stated they expected all residents to receive the correct consistency on their meal tray and if they did not, the resident could choke and get pneumonia. 10NYCRR 415.14 (d-e)

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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 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. 33421 Based on observation, record review, and interviews during the recertification survey conducted 9/23/2024-9/26/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for 1 of 1 main kitchen. Specifically, in the main kitchen food was not maintained at proper temperatures, there was outdated food, and the dishwasher was not in proper working order. Findings include: The facility policy, Cleaning Standards, revised 1/2023, documented high standards of cleanliness and sanitation would be defined and maintained. Cleaning was defined as the use of water, chemicals, and elbow grease to remove all food and debris from equipment and work services. Sanitizing was the use of chemicals or temperature to kill microorganisms remaining on surfaces after they have been cleaned. The facility policy, Food Storage, revised 5/10/2024 documented sufficient food storage facilities were provided to keep foods safe, wholesome, and appetizing. Food would be stored in an area that was clean, dry, and free from contaminants. Food would be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. The facility policy, Rapid Cooling of Food, revised 1/2023 documented time/temperature for food safety would be maintained at temperatures >135 or cooled to temperatures 40 degrees or below. Time/temperature control for food safety including meats, eggs, poultry, seafood, cut melon, milk, yogurt, and cottage cheese pose a risk for growth of harmful pathogens when kept in temperature danger zones for greater than 4 hours. The procedure documented the following: - do not cover until cooled - measure temperature of product at final temperature then record; record time reached to 135 degrees. After 60 minutes record temperature. At the second hour product should have been at or below 70 degrees, if not obtained, product must be discarded. Record time, temperature and initial for each hour up to the 6th hour or until the product reached 40 degrees or below. Scrambled Eggs: During an observation on 9/24/2024 at 11:42 AM scrambled eggs in a closed one-gallon plastic container were in the reach in cooler and were labeled with the date of 9/24. The eggs were measured at 94 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/2024 at 12:10 PM, [NAME] #44 stated the cooked scrambled eggs were put into the reach in cooler right after breakfast which was between 8:30 AM and 9:00 AM. The stated they did not check the temperature of the eggs or monitor them after they were put into the cooler. The leftovers were usually used for the pureed option on the next day's meal service. Meat could be left out after it was cooked to cool down slowly for about 2 hours, but they did not remember the cooling requirements after that. They did not document the cooling process and they were not aware the eggs needed to be cooled properly. During an observation and interview on 9/24/2024 at 12:16 PM, the scrambled eggs were measured by the surveyor and [NAME] #44 at 87 degrees Fahrenheit. [NAME] #44 stated the scrambled eggs were not cooled properly and they would voluntarily discard the eggs. During an interview at 9/24/2024 at 12:26 PM, Food Service Director stated cooling was done by cutting in half large roasts or icing it down to get to a temperature or below 41 degrees Fahrenheit. They stated the cooling time was completed within four hours; however, they were not sure. They stated the scrambled eggs that were measured over 90 degrees Fahrenheit and were in the cooler for over three hours, did not meet the cooling requirements, and should have been discarded. Improper cooling/cold holding turkey salad: During an observation and interview on 9/24/2024 at 11:46 AM, there was a large bowl of turkey salad located in the walk-in cooler covered with multiple layers of plastic wrap which measured at 49.6 degrees Fahrenheit. The Food Service Director stated it was made by [NAME] #44. During an interview on 9/24/2024 at 12:04 PM, [NAME] #44 stated they made the turkey salad approximately 30 minutes ago. They ground the turkey in a food processor, added mayonnaise from the walk-in cooler, mixed it together in a bowl, covered it with plastic wrap, and returned it to the walk-in cooler. They stated it should be cooled to the proper temperature, and the proper temperature was the walk-in cooler temperature, but they were not sure what that numerical temperature was. They stated they took and documented food temperatures during and after cooking, but they did not document or measure a temperature of the turkey salad. When food needed to be cooled down quickly, they used an ice bath, however, they were not sure the time limit required to properly cool food. During an observation and interview on 9/24/2024 at 12:22 PM, the temperature of the turkey salad was remeasured with [NAME] #44 and measured at 49.5 degrees Fahrenheit. [NAME] #44 stated the turkey salad was not cooling properly. The product was uncovered and moved to the walk-in freezer to rapidly cool the product for today's dinner meal. During an interview and observation at 9/24/2024 at 12:26 PM, the Food Service Director stated the turkey salad was not cooled properly because it did not change temperatures after being in the cooler for nearly one hour. During an observation on 9/24/2024 at 1:33 PM, the temperature of the turkey salad was measured with [NAME] #44 at 40 degrees Fahrenheit. Corporate Registered Dietitian #45 was showing [NAME] #44 how to complete a cooling log sheet. Outdated food in the kitchen: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 9/24/2024 at 11:42 AM, a closed one-gallon plastic container located in the reach in cooler located opposite the walk-in cooler contained cooked rice that was labeled with the date 9/20/2024. During an interview on 9/24/2024 at 12:18 PM, [NAME] #44 stated the leftover rice had been in there for more than three days and should have been discarded. During an interview at 9/24/2024 at 12:26 PM, the Food Service Director stated leftovers were discarded after three days and the rice should have been discarded. They stated they were responsible for checking the coolers along with the cooks, and this process was not documented. Unclean and uncleanable surfaces/ steam table in disrepair/ dishwasher out of service: During an observation and interview on 9/23/2024 at 10:34 AM the main kitchen steam table had no lights to signify that it was functioning, and the front service rail bars of the steam table were taped in the corners (not smooth and easily cleanable). The front of the oven doors had dried debris on them, the handles on the sink were dripping, the basement dry food storage area had a box with folded boxes in an area near the entry door, and there was an unsanded and unpainted dry wall patch on the left wall near the hallway entrance approximately 1-foot by 1-foot. The Food Service Director stated they recently discussed concerns about the steam table to maintenance and Administration about it needing to be fixed or replaced. During an interview on 9/25/2024 at 3:22 PM the Administrator stated they were aware the dishwasher was broken, and disposable plates and utensils were used during that time. They called 3 different contractors, and one was able to get the parts needed to repair it. Additionally, the steam table lights not working were not a major concern if staff was taking temperatures of food prior to, during, and after meal services. The surgical and duct tape and zip ties holding together the tray line bars were not cleanable surfaces and would be corrected soon. During an interview on 9/26/2024 at 10:09 AM the Director of Food Services #33 stated when the dishwashing system was not functioning properly, they notified maintenance and the Administrator. 10NYCRR 415.14(h) 43754