STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335590	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pontiac Nursing Home	303 East River Road Oswego, NY 13126

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification and abbreviated survey (reference # 532839 [NY00357482]) conducted 9/8/2024 - 9/12/2024, the facility did not ensure food was prepared, distributed, stored, and served in accordance with professional standards for the facility's food services. Specifically, the facility did not ensure prepared foods were cooled properly, stored properly, the food on the steam tables were served at an appropriate temperature during meal service, and nutrition rooms and storage areas were maintained in a clean sanitary condition. Findings included: The facility policy General Sanitation of Kitchen, reviewed 10/8/2024, required defined cleaning tasks, assigned responsibilities, and staff training. The facility did not follow this policy, as nutrition rooms and storage areas had not been maintained in clean and sanitary conditions.The facility did not have a food storage policy, food service policy, food handling policy, or pest policy as requested on 9/10/2025. Improper cooling:The facility's Cooling Log Sheet documented food must be cooled from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two (2) hours or less. On 6/5/2025, 6/30/2025, 7/8/2025, 7/16/25, 7/21/2025, and 7/26/2025 macaroni salad and pasta salad were documented with temperatures that ranged from 73 degrees Fahrenheit to 78 degrees Fahrenheit after two (2) hours of cooling had been completed. No corrective actions were documented on those dates. During an interview on 9/10/2025 at 11:35 AM, the Food Service Director stated proper cooling allowed for six (6) hours to cool foods down to 41 degrees Fahrenheit and it should have been checked every 2-hours during the cooling process. They were not aware that food was required to have been cooled from 135 to 70 degrees Fahrenheit within two (2) hours. They stated that no corrective action was done for the items listed on the cooling log that had temperatures over 70 degrees Fahrenheit, those items should have been discarded and the process started over. Improper food storage (raw over ready to eat foods):During an observation and interview on 9/9/2025 at 11:49AM, the activities room refrigerator contained a dozen raw eggs stored directly above a drawer full of bottles of pop. The Rehab Director stated they were not aware of the storage requirements for the raw eggs and switched the location of the eggs and pop to avoid any possible cross-contamination. During an interview on 9/10/2025 at 11:35 AM, the Food Service Director stated the raw eggs should not have been stored above the ready to eat food items (bottles of pop) because that was a potential source of cross-contamination. Improper hot holding:During an observation on 9/9/2025 at 12:31 PM, the first-floor dining tray line served food from three (3) of the four (4) bays on the steam table. Tomato soup in the first bay was measured at 156 degrees Fahrenheit, grilled cheese sandwiches in the second bay were measured at 130 degrees Fahrenheit, and the fourth bay contained gravy at 90 degrees Fahrenheit, mashed potatoes at 108 degrees Fahrenheit, and riblets at 122 degrees Fahrenheit. The fourth bay did not have the light on by the knob like the first two bays and it did not appear to have been turned on. During an interview on 9/10/2025 at 2:00 PM, Dietary Aide #32 stated the third bay on the first-floor dining room's steam table did not work, the first, second, and fourth bays worked properly. They stated if the light wasn't on for the bay, then they probably didn't turn it on, and nothing should have been located in there because it was important food was kept hot during service for food safety and to ensure the residents received an enjoyable meal. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 9/10/2025 at 2:10 PM, the fourth bay of the steam table was on, and the indicator light was illuminated. During an interview on 9/10/25 at 3:22 PM, the Food Service Director stated food service staff should not have used the steam table for service if it wasn't turned on. Staff were supposed to turn it on about 30-minutes before service so they could ensure it was hot and ready during service. They stated all hot foods should have been maintained at or above 140 degrees Fahrenheit during meal service. They stated it was important the temperature of the food was maintained during service to prevent the growth of bacteria and to prevent food borne illness. Unsanitary conditions:During an observation on 9/8/2025 at 6:30 PM, the walk-in cooler had some white spills (both liquid and dried) on the floor below the milk shelving. On 9/9/2025 at 12:58 PM, the walk-in cooler had a significant amount of liquid milk spilled beneath the shelving that was tracked across the cooler floor and again on 9/10/2025 at 11:30 AM. During an observation and interview on 9/9/2025 at 11:14 AM, the second-floor nourishments room contained a pitcher of brown stagnant water located in the cupboard beneath the sink. There was a leak in the plumbing and dried puddle of brown liquid present within the cupboard and a hole through the back wall. A brown stained bed sheet was also balled up under the sink. Food debris and spills were present under the sink and around the refrigerator. The Environmental Services Director stated they were not aware of the leak and staff should have notified them so they could have cleaned and repaired the area. During an interview on 9/10/2025 at 11:35 AM, the Food Service Director stated the walk-in cooler was cleaned as needed. They stated they have had a problem with the milk leaking and that stained the floor beneath the shelving. They stated staff mopped that when it leaked, and they were not aware that puddles of milk were observed on the floor of the cooler for three days of survey. They stated the nourishment rooms should have been clean, the leaking sink, hole in the wall, and food debris provided food, water and potential harborage for pests. The Food Service Director stated the kitchen and nourishment storage areas should have been clean, with smooth and easily cleanable surfaces, without leaks and spills, so they could provide a better-quality food environment for the residents. 10NYCRR 415.14(h)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for one (1) of one (1) resident (Resident #52) reviewed and twelve (12) of twelve (12) anonymous residents present during a resident group meeting. Specifically, Resident #52 had intact decision-making ability, and the facility involved the resident's family in financial decisions without asking the resident and informed the resident they could not utilize another cognitively intact resident's cellphone even with permission; and twelve residents present at the resident group meeting voiced concerns they were not allowed to go to the enclosed area outside. Findings include:The facility was unable provide a resident rights and resident cellphone policy as requested.The facility admissions packet documented the residents as nursing home residents in New York State had the right to retain and use personal possessions, the right to privacy and confidentiality regarding medical, personal and financial affairs, to send and receive mail without interference, and to participate in social, religious, and community activities.1) Resident #52 had diagnoses including polyneuropathy (damaged peripheral nerves), hypothyroidism, and hypertension. The 5/10/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment. There was no documented evidence of a financial power of attorney.The 2/12/2025 Social Worker #30 progress note documented the resident had a Brief Interview of Mental Status score of 11 (moderately impaired cognition) but was alert and oriented to person, place, and time.The 4/11/2025 Social Worker #30 progress note documented the resident had a delivery of seven boxes from online shopping and was informed by staff the resident ordered additional items. They informed the resident they could not buy anything more because their room was only able to hold a small number of items. The resident was unhappy with the conversation and muttered under their breath as they left the room. Social Worker #30 called the resident's parents due to a history of the resident buying items they did not use and a large unpaid credit card debt.The 4/16/2025 Social Worker #30 progress note documented they and the resident's parents had a meeting with the resident which resulted in the resident giving their parents their debit card and getting $100 a month to spend.The 8/12/2025 Nurse Practitioner #9 progress note documented the resident had good judgment, was oriented to time, place and person, and had normal recent memory and normal remote memory. During an interview on 9/9/2025 at 10:04 AM, Resident #52 stated they were told they were ordering too many deliveries, and the facility sent an email to their parents to tell on them and forwarded the resident's debit card to their parents. Resident #52 stated when their cellphone broke, they used another resident's phone with that resident's permission. They were pulled out of an activity by the social worker and told they were not allowed to use another resident's cell phone. They stated the facility also sent another email to their parents and told them the resident was not allowed to use another resident's cellphone per their policy and the resident needed to order their own.During an interview on 9/11/2025 at 3:54 PM, Social Worker #30 stated residents should not use each other's cellphones, and it was discouraged to eliminate any conflict. They had a facility cellphone a resident could use if they did not have their own. They informed one resident that Resident #52 should not use their cell phone even though the resident had stated they were fine with it. They stated they highly discouraged it due to cellphones being able to access social media and Resident #52 posting information on social media. The other resident stated their phone was not able to access social media. Resident #52 had a history of posting comments online which the Director of Nursing had to remove. Resident #52 was alert and orientated and could be forgetful but was able to make their own care decisions. They involved Resident #52's parents when the resident was ordering too many packages and when they used another resident's cellphone. The resident was not responsible and had a history of overspending on things they did not need and not paying their bills (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per their family. They saw the online shopping boxes come in and was concerned as they did not want the resident to spend all their money. They were aware the resident was an adult, and they did not like the facility involving the resident's parents. They held the resident's debit card and had the resident's parents come in for a meeting at which time the resident agreed for their parents to have the card and a monthly amount the resident had access to.2) During a resident meeting on 9/9/2025 at 10:04 AM 12 of 12 anonymous residents stated they were not allowed to go outside by themselves, even in the fenced in areas of the facility grounds. Several residents stated as alert and orientated residents they should be able to go outside if they wanted to.The 6/10/2025 and 7/8/2025 Resident Council Meeting Minutes documented the residents were asking about increased outdoor access and it was referred to the Administrator. There was no documented follow up from the Administrator.During an interview on 9/11/2025 at 3:54 PM, Social Worker #30 stated residents, even alert and orientated residents, could not go out to the fenced in patio or go outside by themselves because it was a liability. A resident was allowed to go outside with friends and family present, but they were just trying to prevent accidents when residents were by themselves. It was for safety reasons. During an interview on 9/12/2025 at 9:10 AM, Certified Nurse Aide #17 stated even if a resident was alert and orientated, they needed to have someone with them to sit outside such as activities staff or a family member. They did not know why residents could not go outside by themselves if they were alert and orientated. The back patio was locked, and a code had to be put in by staff to access it.During an interview on 9/12/2025 at 9:55 AM, Registered Nurse Supervisor #4 stated alert and orientated residents were not allowed outside by themselves unless they had an order for a pass by the provider. They did not know why, it was just facility policy. The facility patio doors were locked and alarmed, but they unlocked them for families of residents who wanted to sit outside with a resident.During an interview on 9/12/2025 at 10:15 AM, Activities Supervisor #31 stated alert and orientated residents were not allowed to go outside alone. There was only one resident who was care planned for to be able to. They stated the residents were adults and should be allowed to go outside. They were trying to work on changing it.10 NYCRR 415.5(d)(1)(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for four (4) of four (4) residents (Residents #6, #21, #41, and #44) reviewed. Specifically, Resident #6 did not have a care plan that included the use of bed rails; Resident #21 did not have a current care plan addressing behaviors and diabetes with insulin use; Resident #41's care plan was not reviewed and/or revised after Minimum Data Set assessments; and Resident #44's care plan did not include the use of a urinary catheter (a tube to drain urine from the bladder). Findings include: The facility policy Comprehensive Care Planning, reviewed 9/16/2019, documented an individualized care plan was initiated by a registered nurse upon admission for all residents. The interdisciplinary team reviewed the care plan quarterly following the Minimum Data Set assessment completion; with a significant change; a return following a hospital admission; and as needed. All disciplines were responsible the plan of care was reviewed and documented goals, interventions, monitoring notes, and was updated as needed. 1) Resident #6 had diagnoses including morbid obesity and epilepsy (seizure disorder). The 4/26/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, required moderate assistance for bed mobility, and did not use bed rails. During an observation and interview on 9/8/2025 at 6:38 PM, Resident #6 had bilateral enabler bars on their bed. The resident stated they used them when rolling in bed. The Comprehensive Care Plan documented a self-care deficit due to weakness and anxiety. Interventions included limited assistance for bed mobility and encourage resident to participate in bed mobility. There was no documented evidence of the use of bed rails. During an interview on 9/11/2025 at 1:52 PM, Registered Nurse Supervisor #4 stated physical therapy determined if a resident was appropriate for bed rails and updated the care plan to reflect that. They were not sure if the resident had bed rails. During an interview on 9/12/2025 at 9:15 AM, the Director of Rehabilitation stated if they determined bed rails were appropriate, it should be in the activities of daily living care plan under bed mobility. Resident #6 had bed rails, and their care plan did not reflect this. 2) Resident #44 had diagnoses including urinary retention, chronic obstructive pulmonary disease (airway disease), and hypertension (high blood pressure). The 8/18/2025 Minimum Data Set assessment documented the resident was cognitively intact, did not have any behaviors, and had an indwelling urinary catheter. The Care Area Assessment Summary triggered an indwelling catheter and was addressed in the care plan. The 8/14/2025 physician order documented to change the resident's urinary drainage device every 30 days. There was no documented evidence of a Comprehensive Care Plan related to the resident's urinary catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/2025 at 11:05 AM Certified Nurse Aide #17 stated they knew how to care for a resident by the resident care instructions in the electronic medical record and by the book at the nurses' station. During an interview on 9/12/2025 at 9:13 AM Registered Nurse Supervisor #4 stated the staff knew how to care for a resident by the resident care instructions in the electronic medical record and by the paper care guide at the nurses' station. The resident care instructions did not always list everything needed due to the facility still transitioning to the electronic medical record. A resident who had a urinary drainage device should have a care plan. They did not know why Resident #44 did not have a care plan for their urinary drainage device. The resident did not have an admission assessment, so it was likely the care plan did not generate due to it not being triggered on the admission assessment. 3) Resident #21 had diagnoses including anxiety, intellectual disabilities, and diabetes. The 6/14/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment, did not exhibit behaviors, and received insulin injections, antipsychotics, antianxiety, and antidepressants daily. The Care Area Assessment Summary triggered behavioral symptoms and was addressed in the care plan. The Comprehensive Care Plan did not address the resident's behaviors, the diagnoses of diabetes, or the administration of insulin injections. Physician orders documented: -On 5/16/2025 sertraline (treats depression) 20 milligrams orally daily related to depression. -On 5/22/2025 buspirone (treats anxiety) 10 milligrams orally twice daily related to anxiety disorder. -On 6/9/2025 Abilify (mood stabilizer) 7 milligrams by mouth at bedtime related to anxiety disorder. -On 7/23/2025 Lantus (long-acting insulin) 80 units subcutaneously daily in the morning related to diabetes. Nursing progress notes documented the following: -On 7/21/2025 at 11:15 PM by Licensed Practical Nurse #5 the resident was experiencing behaviors beyond their baseline. The resident refused all medications and was cooperative with care after they were reapproached and offered coloring sheets and pens. The resident closed their eyes and pretended to sleep in their wheelchair and covered their face with a blanket. -On 8/23/2025 at 10:40 AM by Licensed Practical Nurse #5 the certified nurse aide staff informed them the resident was throwing things, cursing, and attempting to ambulate without their wheelchair despite being wheelchair bound and was threatening to hit the staff. The resident stated their green pen had been taken away and they wanted it back. -On 8/27/2025 at 5:24 AM by Licensed Practical Nurse #19 the resident came out of their room demanding a pen. They observed the resident repeatedly going behind the nurses' desk, standing at the desk frantically looking for a pen. At 5:30 AM, the resident was observed throwing a cup behind the nurses' station due to no pen available. At 5:59 AM, the resident was yelling staff was poisoning residents. They took their shirt off out of protest and staff attempted to deescalate without effect. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was observed at the following times: -On 9/8/2025 at 6:39 PM, self-propelling in their wheelchair in the hallway, asked the surveyor for their pen and persistently asked and raised their voice when they did not get the pen. -On 9/9/2025 at 1:29 PM, seated in their wheelchair just outside the nurses' station. They went behind the nurses' station and grabbed a stuffed animal on the desk. Licensed Practical Nurse #25 told the resident to let it go as it was not theirs and belonged to another resident. The resident refused to give the stuffed animal back. At 1:31 PM, they were in their wheelchair in the hallway with the stuffed animal. They raised their voice and demanded Certified Nurse Aide #26 write a name on a piece of paper for them with a heart. -On 9/10/2025 at 10:08 AM, in their wheelchair in the hallway yelling about not having a purple pen. The resident refused to go to their room and get changed with Certified Nurse Aide #26. Licensed Practical Nurse #25 stopped in the hallway where this encounter took place and attempted to reapproach the resident regarding getting changed. The resident then threw a pen down the hallway. There was no documented evidence of care planned interventions to address the resident's behavioral symptoms. During a telephone interview on 9/11/2025 at 12:55 PM, Certified Nurse Aide #11 stated the care plan was now located in the electronic record and there was a button they clicked on to see it. That was their normal unit, and they tried to reference the care plans at least every other day because things changed. The care plans used to be on paper, so this was a change. The care plan told them how to care for the residents. Resident #21 was diabetic because they were on a consistent carbohydrate diet. They were not sure if that was on the care plan or not. The resident was behavioral at baseline. They witnessed the resident hitting, kicking, throwing things, and refusing care. The care plan should document the resident had behaviors and interventions they should try when for behaviors, but they were not sure if it did. During an interview on 9/11/2025 at 3:56 PM, Licensed Practical Nurse #13 stated care plans were completed by the registered nurse supervisor. They did not know how to access a care plan in the computer, but they used to be on paper. The purpose of the care plan was to drive the care, inform them of the resident's needs and what care was required. Resident #21 had behaviors and was non-compliant. The resident should have a behavior care plan because staff should know how to handle the behaviors. The resident was also diabetic and was on insulin which was a high-risk medication so there should be a care plan for that. During an interview on 9/12/2025 at 9:55 AM, Registered Nurse Supervisor #4 stated they and the other supervisors were responsible for care plans. Residents who were diabetic should have a specific care plan and should include Insulin. The care plan instructed what needed to be followed and what needed to be monitored such as labs and blood sugars. Residents with behaviors should also be care planned for that. Resident #21 had been there for a long time, so they had a paper care plan. Upon viewing the paper care plan with the surveyor, they stated it was not reviewed quarterly as required. The resident's electronic care plan did not really have anything in it and had fallen by the wayside. One care plan came from physical therapy, one from activities, and one from section GG of the Minimum Data Set assessment and that was all the resident had on their care plan. The care plans switched to electronic in June, but it was impossible to get them into the electronic record. 10NYCRR 415.11(c)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility failed to ensure the services provided or arranged by the facility, as outlined by the comprehensive care plan, met professional standards of quality for two (2) of five (5) residents (Resident #13 and 41) reviewed. Specifically, Residents #13 and #41 were administered long-acting insulin greater than 3 hours past the scheduled administration time and the insulin pens were not primed (removing trapped air) prior to dialing in the ordered dose. Findings include:There was no documented evidence of a facility policy on medication administration or insulin administration. 1) Resident #13 had diagnoses including diabetes. The 8/5/2025 Minimum Data Set assessment documented the resident had intact cognition and did not receive daily insulin injections. There was no documented Comprehensive Care Plan addressing the resident's diabetes or administration of insulin. During an interview on 9/8/2025 at 7:27 PM, Resident #13 stated they did not get their medications on time. They were supposed to get their medications, including the insulin, before breakfast but often did not get them until 10:00 AM or 11:00 AM. They had incidents when their blood sugars were high.The 7/29/2025 physician order documented Basaglar Kwik Pen (glargine, a long-acting insulin) solution pen injector 100 units/milliliters inject 25 units subcutaneously one time a day. During an observation on 9/10/2025 at 11:06 AM, Licensed Practical Nurse #5 administered 25 units of Basaglar Kwik Pen insulin. They did not prime the needle prior to dialing in the ordered dose. The resident complained to the nurse their medications were late and requested their glucose be checked prior to administration. The result of the glucose finger stick was 206.The September 2025 Medication Administration Record documented the 25 units of Basaglar Kwik Pen insulin was scheduled for 8:00 AM and was administered by Licensed Practical Nurse #5 on 9/10/2025.There was no documented evidence the provider was contacted regarding the delay in administration. 2) Resident #41 had diagnoses including diabetes. The 7/9/2025 Minimum Data Set assessment documented the resident had intact cognition and received daily insulin injections.The 6/2/2025 Comprehensive Care Plan documented the resident had unstable blood glucose levels. Interventions included administer medications as prescribed.The 8/25/2025 physician order documented Lantus (glargine, a long-acting insulin) Solostar subcutaneous solution Pen-injector 100 units/milliliters inject 120 unit subcutaneously every 12 hours. During an observation on 9/10/2025 at 11:22 AM Licensed Practical Nurse #5 administered 60 units of Lantus Kwik Pen insulin, removed the needle, applied a new needle, and administered a second dose of 60 units to equal 120 units. They did not prime the needles prior to dialing in the ordered doses.The September 2025 Medication Administration Record documented 120 units of Lantus Solostar Pen-injector was scheduled for 8:00 AM and 8:00 PM. The 9/10/2025 8:00 AM dose was administered by Licensed Practical Nurse #5.There was no documented evidence the provider was contacted regarding the delay in administration. During an interview on 9/10/2025 at 11:58 AM, Licensed Practical Nurse #5 stated they were never taught to prime pen needles prior to dialing up the dose. Residents #13 and #41 received their long-acting insulin late that day and they thought that was okay because there was no peak time. They would share in shift report they gave the insulins late and needed to call the provider to let them know as well. Insulins were prioritized and typically given on time. Short acting insulins were their focus and were given on time.During a follow up interview on 9/11/2025 at 12:02 PM, Licensed Practical Nurse #5 stated they did not notify the provider about the late insulin administration on 9/10/2025 but should have.During an interview on 9/11/2025 at 10:46 AM, Registered Nurse Supervisor #4 stated medications should be passed within one hour before or one hour after the scheduled time. If the nurse was behind on their med pass, the physician should be called to get permission to give the medication late and find out if the provider wanted to recheck the glucose before administering the insulin. An order should be taken to say it was okay to give at that later time. Insulin pens only had to be primed when they were first opened. Needles did not need to be primed. They were not aware that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	insulin was administered late yesterday or if a provider was notified.During an interview on 9/12/2025 at 9:33 AM, Nurse Practitioner #9 stated if long-acting insulin was scheduled for 8:00 AM a reasonable time frame it should be administered was an hour before or after. If insulin was not administered within that time frame they expected to be notified because there might be a need to adjust the dose. They were not notified Residents #13 and #41 did not receive their morning insulin until after 11:00 AM on 9/10/2025 and should have. 10NYCRR 415.11(c)(3)(i)

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	335590	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pontiac Nursing Home	303 East River Road Oswego, NY 13126

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure residents received care and treatment in accordance with professional standards of practice and the comprehensive person-centered care plan for one (1) of one (1) resident (Resident #20) reviewed. Specifically, Resident #20 had a change in condition and was not assessed timely by a qualified professional; Licensed Practical Nurse #25 notified Nurse Practitioner #9 via text message and there was no documented evidence of orders received for a chest x-ray and the application of oxygen; Licensed Practical Nurse #25 did not document a change in condition or that a medical professional and family were notified; and there was a delay in notifying the provider of the radiology results. Findings include: The facility policy Notification of Significant Changes, last reviewed 6/30/2023, documented the facility notified the resident, the resident's physician(s), and if known, the resident's legal representative or an interested family member when there was a significant change in the resident's physical, mental, or psychosocial status such as a deterioration in health either life threatening conditions or clinical complications as well as when there was a need to commence a new form of treatment. When a significant change was identified, the staff member who identified the change notified their Nurse Manager/ Shift Supervisor. The Registered Nurse Supervisor completed an assessment and notified the attending physician and the resident's legal representative as warranted. Notifications were documented in the progress notes with designation to the 24-hour report. Notification attempts to the family/ resident representative were documented in the medical record. Resident #20 had diagnoses including pneumonia, dysphagia (difficulty swallowing) amyotrophic lateral sclerosis (a progressive neurological disease). The 9/3/2025 Minimum Data Set Assessment documented the resident had severe cognitive impairment, required substantial/ maximum assistance with most activities of daily living, received nutrition via tube feeding (a tube placed in the stomach), and did not receive oxygen therapy. The Comprehensive Care Plan initiated 9/3/2025, documented the resident had little or no activity involvement related to immobility, physical limitations, disease process, and was non-verbal. Interventions included communication with a white board, and the resident would nod yes/no or thumbs up/ down to respond. The 8/28/2025 Registered Nurse Supervisor #4 admission assessment documented the resident was non-verbal, not short of breath, and was not on oxygen. Resident #20 was observed at the following times:-On 9/8/2025 at 6:57 PM, resting in bed with their eyes open and labored breathing. There was an oxygen concentrator set to 2 liters next to the bed and the nasal cannula tubing was on the floor and not on the resident. At 8:50 PM, lying in bed with the nasal cannula on and oxygen running at 2 liters. Their breathing was labored. -On 9/9/2025 at 8:44 AM, resting in bed with labored breathing. The nasal cannula was on their lap on top of the bedsheet and not on the resident. At 1:07 PM, the resident was in bed with the nasal cannula on and oxygen running at 2 liters. Their breathing was labored. -On 9/10/2025 at 9:32 AM, 10:38 AM, and 1:51 PM, lying in bed with the nasal cannula on, running at 2 liters with humidity. Their breathing was labored, and they were diaphoretic (sweating). There was no documented evidence of a physician order for the oxygen therapy, a nursing note indicating why oxygen was initiated, or a registered nurse assessment from admission on [DATE] through 9/10/2025.The 9/8/2025 radiology report documented a chest x-ray was performed at 1:51 PM. There was minor left base consolidation which could be atelectasis or pneumonia. The report was signed by Radiologist #29 at 3:29 PM and the results were reported to the facility at 3:30 PM. There was no documented evidence of a physician order for the chest x-ray, or a nursing note that indicated why it was completed. There was no documented evidence the medical provider was made aware of the x-ray results upon the facility receiving the report. The 9/10/2025 at 10:49 AM Registered Nurse Supervisor #4 progress note documented the chest x-ray results were read to the Medical Director on the phone (2 days after the results were sent to the facility). After they relayed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's assessment, the Medical Director advised to continue monitoring of the resident. There were no documented vital signs from 8/29/2025-9/10/2025. The resident passed away on 9/10/2025 at 11:50 PM. During a telephone interview on 9/11/2025 at 1:03 PM, Certified Nurse Aide #11 stated Resident #20 was not on oxygen when they were admitted . The resident had a decline a few days ago and when they came in for their shift, the resident was on oxygen. They did not know what day that was. During an interview on 9/12/2025 at 9:27 AM, Licensed Practical Nurse #25 stated Resident #20 had a change in condition on 9/8/2025 and started death breathing, their oxygen saturation on room air was 91 percent, and their respirations were 30. They texted Nurse Practitioner #9 and was instructed to put the resident on oxygen at 2 liters via nasal cannula and obtain a chest x-ray. They initiated the oxygen and faxed a requisition to the imaging company. They did not enter the orders, but they should have. They did not document a note, but they should have. They were just too busy. The resident's family was at the bedside at the time. They thought they told a registered nurse supervisor, but they were not sure who they told, and the registered nurse supervisor never came to see the resident. During an interview on 9/12/2025 at 9:55 AM, Registered Nurse Supervisor #4 stated they were notified of changes in condition so they could assess the resident. They were not notified of a change in condition on 9/8/2025 for Resident #20. They worked from 11:00 AM to 7:00 PM on that day. They knew a chest x-ray was ordered because a report came over on the fax. They showed the report to Nurse Practitioner #9 on 9/10/2025 and they said they were not assigned to the resident and did not have access to their medical record and to give the results to the Medical Director. They stated they did not assess the resident until 9/10/2025 when they called the Medical Director with the radiology results. The Medical Director asked what the resident looked like, so they went to assess the resident then. There was not an order in the system for a chest x-ray or for oxygen but there should have been. There should be a nursing note as well but there were no notes for the resident between 9/7/2025 and 9/10/2025. They were not sure why the oxygen or the chest x-ray was ordered. During a telephone interview on 9/12/2025 at 10:11 AM, Nurse Practitioner #9 stated Resident #20 was not assigned to them, and they did not have access to their medical record. They did not recall being notified of a change in condition or giving any orders for oxygen or a chest x-ray. 10NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025 the facility did not ensure the resident environment remained free of accident hazards for one (1) of four (4) residents (Resident #41) reviewed. Specifically, Resident #41 had a physician order for nectar thick consistency liquid and was provided thin liquid consistency hot cocoa. Additionally, Resident #41 was unhappy with their thickened liquids diet, was occasionally non-compliant and was not referred to speech language pathology for their new diet or care planned for their non-compliance. Findings include:The facility policy Dysphagia and Diet Consistency Changes, last reviewed 2/17/2022, documented dysphagia (difficulty swallowing) diets would be individualized with modifications made by the Speech-Language Pathologist, Occupational Therapist, Registered Dietitian, and physician as needed. Residents with observed indicators of dysphagia would be referred to the Speech-Language Pathologist for an evaluation. The evaluation would determine diagnoses, proper fluid thickness, and may recommend additional swallowing studies. The facility policy Comprehensive Care Planning, reviewed 5/5/2021, documented a care plan was to be individualized for each resident using a person-centered approach. Measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs that were identified from admission assessment, comprehensive assessments, and the application of the Care Area Assessment. Additional problems, strengths, or needs identified by the interdisciplinary team would be included as appropriate. All disciplines are responsible for reviewing the plan of care and documenting goals, interventions, monitoring notes, and updating as needed. Resident #41 had diagnoses including bacterial pneumonia, schizoaffective disorder bipolar type, and hypertension (high blood pressure). The 4/8/2025 Minimum Data Set documented the resident was alert and oriented, had no behavioral symptoms, required set up for eating, and had no swallowing disorders.The 8/25/2025 hospital discharge summary documented the resident had a diagnosis of pneumonia and their diet consistency was soft and bite size solids with a nectar thick liquid consistency. The resident had swallowing difficulties, and they were to have follow up appointments per the facility protocol.The 8/25/2025 physician order documented the resident was on a carbohydrate controlled with regular texture in soft bite sized solids (diet) and nectar/mildly thick consistency.There was no documented evidence the resident was referred to speech language pathology for dysphagia and the need for nectar thick liquids. Resident #41's certified nurse aide accountability record and assignment documented the resident was on a consistent carbohydrate diet, regular solids, and thin liquids.During an observation on 9/8/2025 from 7:41 PM to 8:36 PM, Resident #41 stated to Certified Nurse Aide #3 they wanted to drink a soda. Certified Nurse Aide #3 told the resident they needed to stick to their liquid consistency. They did not have any thickener for the soda as the kitchen did not send any the thickener packets. The kitchen offered to send up thickened ginger ale. The resident declined and stated they wanted their own soda and would get it themselves. Certified Nurse Aide #3 reminded the resident they could not have it as it was a thin liquid. The resident replied they had soda last night and the night before. Registered Nurse #8 stated they found thickener packets, and the resident allowed them to thicken the soda.During an observation and interview on 9/9/2025 from 12:19 PM to 12:30 PM, Resident #41 had a bottle of soda at their table in the dining room. Registered Nurse Supervisor #4 stated the resident was on nectar thick liquids and would not give the soda up and walked away from the resident. The resident had hot cocoa provided by staff that was thin when stirred. When brought to the attention of staff, Registered Nurse Supervisor #4 and Dietary Aide #14 stated the cocoa was thickened. Dietary Aide #14 stated sometimes the drink automatically thickened when thickener was added and sometimes it took a minute. It depended on who served the drink if they waited for the drink to thicken prior to serving. They stated Resident #41's drink was thickened with a thickener packet by the Food Services Director. Licensed Practical Nurse #5 informed the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident they were going to make the resident a cup of cocoa. Licensed Practical Nurse #5 stated the thickener packets were to be added to 4 ounces of liquid.Resident #41's 9/9/2025 meal ticket documented the resident was to receive mild thick beverages. During an interview on 9/9/2025 at 12:29 PM, the Food Services Director stated they added one packet of thickener before they gave Resident #41 their hot cocoa. Sometimes they waited until the drink thickened to give it to the resident and sometimes, they did not. They stated the thickener liquid they had in the kitchen worked better than the packets. They did not realize, until Licensed Practical Nurse #5 had pointed it out, the packet was only for 4 ounces, and the cocoa was 8 ounces, so they should have added two packets to the hot cocoa.A 9/9/2025 physician order documented referral to speech language pathology for upgraded diet consistency. During an interview on 9/11/2025 at 11:05 AM, Certified Nurse Aide #17 stated a resident's diet was listed in the nourishment room, on their face sheet, the Kardex in the electronic medical record and in the certified nurse aide accountability book. Resident #41 was on mildly thick liquids. They came back from the hospital with the new order. The resident was having difficulty with the new liquid texture and would go to the vending machine and get themselves a soda. They stated Resident #41 sometimes let them alter the soda to thicken it, but the resident did not respond well if their soda was taken away. They were unsure if there were interventions in place regarding the resident's refusal to follow their diet. They stated they let the charge nurse know when the resident was not complying with their diet consistency.During an interview on 9/11/2025 at 12:28 PM, the Rehabilitation Director stated they did not have a speech language pathologist on staff at the facility. They sent residents to the local hospital for outpatient services if it was needed. Nursing made the referral for the speech language pathologist. Sometimes the hospital placed a referral for a follow up if a resident returned from the hospital on altered textures. They did not know why the resident did not receive a referral until 9/9/2025 when they returned from the hospital on 8/25/2025. The resident was not happy with their current liquid texture.During an interview on 9/11/2025 at 2:23 PM, Licensed Practical Nurse #5 stated Resident #41 was on altered liquids, and it was new for the resident. Resident #41 was very non-compliant with their diet and needed to be reeducated when they refused. When they first came back from the hospital the resident attempted to have other residents give them thin liquids. They let the nurse practitioner know when Resident #41 was non-compliant with their diet. During an interview on 9/12/2025 at 9:13 AM, Registered Nurse Supervisor #4 stated the hospital sent recommendations for a resident's diet when they were admitted . Resident #41 was on altered liquids when they returned from the hospital on 8/25/2025. The resident was not very compliant with their ordered liquid consistency, and they tried to discuss it with the resident. Sometimes the resident would allow their soda to be thickened. The resident wanted to see the speech language pathologist, so they were working on that. The only intervention in place for the resident's refusals was to educate the resident. The provider was aware of the resident's non-compliance. They were unaware of why it took from 8/25/2025 until 9/9/2025 to get the resident a referral for speech language pathology. During an interview on 9/12/2025 at 10:05 AM, the Director of Nursing stated Resident #41 should have a care plan related to their non-compliance with liquid consistency when it became known to the staff.During an interview on 9/12/2025 at 10:11 AM, Nurse Practitioner #9 stated if a resident returned from the hospital with a new order for altered liquid textures, they should be referred to speech language pathology and did not know why Resident #41 was not referred until 9/9/2025. They should be notified if a resident on altered textures was not adhering to their diet. They were not informed that Resident #41 was drinking regular soda they should have been. 10 NYCRR 415.12(h)(1)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for two (2) of two (2) residents (Residents #7 and #8) reviewed. Specifically, Resident #7 had a significant weight loss that was not assessed timely, interventions were not reviewed after continued weight loss, and the resident was not provided with the ordered nutritional supplement; and Resident #8's tube feeding orders did not meet the calculated nutritional needs of the resident and did not include free water flushes. Additionally, Resident #8 was self-administering their tube feeding without a physician order or determination of physical and mental competency to self-administer the feeding. Findings include: The facility policy Self-Medication Administration, last reviewed 2/2022, documented the comprehensive care team would evaluate the resident to determine if they met the self-administration criteria to include physical and mental ability; the attending physician would initiate an order specifying permission to self-medicate; it would be noted on the medication record the resident self-administers; and the comprehensive care plan would reflect teaching, response, problems, revisions and evaluations of the process quarterly or as necessary. The facility policy Enteral (Tube) Feeding Procedure, last reviewed 2019, documented a bolus (volume of tube feeding formula administered by a syringe at one time) feeding included flushing with the appropriate amount of water per physician's order; the tube must be flushed with the appropriate amount of ordered solution; and if giving more than one medication the tube should be rinsed with 5 milliliters of warm water in between each medication. There was no documented Nutritional Assessment policy. 1) Resident #8 had a diagnosis including stroke and dysphagia (difficulty swallowing). The 8/1/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition; was dependent for eating; had a significant weight loss and was on a physician-prescribed weight loss regime; a gastrostomy tube; and total daily calories the resident received through a tube feeding was 51% or more. The Comprehensive Care Plan documented resident had dysphagia. Interventions included Osmolite 1.5 (a tube feeding formula) at 270 milliliters to run over 1-2 hours 4 times a day. There was no documented evidence the resident self-administered their tube feeding. The 7/28/2025 physician order, discontinued on 9/4/2025, documented the resident was to receive enteral nutrition via gravity (free flowing) or bolus (given all at once): Osmolite 1.5 Cal at 270 milliliters to run over 1-2 hours via pump with 115 milliliters of free water flushes before and after feeding four times a day (total calories 1620, total free water with feedings 920 m). The 9/4/2025 physician order documented the resident was to receive enteral nutrition via gravity or bolus: Osmolite 1.2 four times per day via gravity bolus (237 milliliters, four times per day). The order did not document a water flush, or the resident could self-administer the feeding. (Order provided 1138 total calories per day). The 8/2/2025 Registered Dietitian #6 readmission nutritional assessment documented the resident was receiving Osmolite 1.5 cal at 270 milliliters to run over 1-2 hours four times a day via pump with 115 milliliters of free water flushes before and after feeds; their weight was 168 pounds/76.4 kilograms; their height was pending. The current order was below estimated needs; weekly weights (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be monitored to determine if tube feeding needed to be titrated up; and their recommendation was Osmolite 1.5 at 210 milliliters four times a day which provided 1260 kilocalories, 53 grams of protein, and 640 milliliters of free water. The resident's estimated needs were 1.1 grams/kilograms of protein to equal 84 grams, 25-30 kilocalories/kilogram to equal 2038-2445 calories, and 30 milliliters/kilogram of fluids to equal 2292 milliliters. The resident had the following weights: -on 8/1/2025 168 pounds -on 8/5/2025 168.8 pounds -on 9/5/2025 160.3 pounds (5% weight loss in 1 month) There was no documented evidence the tube feeding volume and water flushes were adjusted to meet the resident's estimated nutritional needs and weight goals. During an interview and observation on 9/8/2025 at 6:59 PM, the resident stated they administered their own tube feedings and water flushes. They were supposed to do their feeding four times a day but sometimes only did it three times if they were feeling sluggish or fell asleep. They used one 237 milliliter carton of Osmolite 1.5 kept in their room in a box next to their sink. They thought they were supposed to use 35 milliliters of water before and after each feeding but used a little more to dilute the feeding so it would flow quicker. There was a new nurse that came in to watch them administer their feeding otherwise they did it on their own without supervision. There was no documented evidence of a resident evaluation, or teaching provided regarding the self-administration of the resident's tube feedings. During a follow up interview and observation on 9/10/2025 at 11:33 AM, the resident stated when administering their tube feeding, they used one carton of Osmolite 1.5 and one plastic drinking cup of distilled water. They alternated between the Osmolite and the water to keep the feeding thin so it would flow quicker. They ended the feeding by flushing with about 40 milliliters of water. They did their own feeding that morning and no one checked in to ensure they had. The plastic cup used to hold the distilled water was measured using a piston syringe and held 180 milliliters. During an interview on 9/10/2025 2:10 PM Licensed Practical Nurse #5 stated the medication pass policy for tube feedings was usually 15-30 milliliters of water before and after the medication pass and 5-10 milliliters in between each medication. It was nursing's responsibility to make sure the feeding was done and administered correctly. They taught the resident to fill the plastic drinking cup to the top which was 240 milliliters. They could not find an order for water flushes with feedings or with medication administration but knew it had been 115 milliliters before and after each feeding. After looking at the feeding in the resident's room they stated it was Osmolite 1.5, but the order was for Osmolite 1.2. The resident should not receive Osmolite 1.5 without an order. During an interview and observation on 9/11/2025 at 9:40 AM the resident had only Osmolite 1.5 in their room and stated they continued to use this for their feeding. The September 2025 Medication Administration Record documented enteral feed order 4 times a day: Osmolite 1.2 four times per day via gravity bolus (1 can, 237milliters, four times per day). With a start (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 9/4/2025. The feeding was documented as being administered at 7:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM starting 9/4/2025 at 8:00 PM through 9/11/2025 at 11:00 AM except for one refusal. During an interview on 9/11/2025 at 10:46 AM Registered Nurse Supervisor #4 stated self-administered tube feedings and medications should be care planned for. Any changes in tube feeding orders came from a recommendation from the dietitian usually via an e mail. The recommendation was reviewed with the provider for approval. Resident #8 was just switched last week from a bolus via a pump to a gravity bolus and the resident was administering it themselves. The nurses should be supervising the resident to make sure it was being administered with the right formula and right amount. The orders did not include any water flushes but should. When giving medications, 60 milliliters of water should be given before and after medication administration. If there were no water flush orders the nurse should obtain one. They watched the resident self-administer their feeding and told them to use 60 milliliters before and after the feeding. During an interview on 9/12/2025 at 11:12 AM, Registered Dietitian #6 stated they typically followed the hospital tube feeding orders to start and adjusted if needed. They e-mailed any recommendations to Registered Nurse Supervisor #4 and the other nursing supervisors. Free water flushes should be part of the order, and each medication pass was a standard of 60 milliliter flush. When Resident #8 was readmitted , they received a bolus feeding four times a day via a pump and their recommendations was 270 milliliters of Osmolite 1.5 four times a day. The resident returned on 8/2/2025 and the recommendation was for 210 milliliters. They received an email on 8/30/2025 from Registered Nurse Supervisor #4 wanting to change from a pump to gravity in preparation for the resident to go home and the feeding amount changed at some point. On 8/30/3035 they recommended 270 milliliters four times. When the resident transitioned to gravity there was not a change in the formula or amount as the resident had been documented to be receiving 270 milliliters of Osmolite 1.5 four times a day. The impact of getting only 237 milliliters of feeding was a shortage of 120 milliliters a day. The 237 milliliters of Osmolite 1.5 would sustain their weight within 3% which would be 163 pounds. The resident dropped to 160 pounds. They were not aware the resident skipped some feedings, or their recommendation was not implemented as an order. Their water recommendation was 115 milliliters before and after the four time a day feeding and was the same recommendation as the 9/4/2025 feeding order. They stated their recommendations should be followed and was not. During a follow up interview on 9/12/2025 at 2:50 PM, Registered Nurse Supervisor #4 stated in a 9/1/2025 email, the registered dietitian stated the resident could be transitioned to a gravity bolus as they were already tolerating 4.5 cans of Osmolite 1.5 a day and their recommendation was 4.5 cans of Osmolite 1.5 a day. When they entered the order, they put in four cans a day, omitting the 0.5 of a can which was a difference of 132 milliliters a day. They also entered it as Osmolite 1.2 rather than Osmolite 1.5 formula. During an interview on 9/12/2025 at 2:22 PM the Medical Director stated caloric requirements were determined by the dietitian and they relied on their expertise and recommendations. They expected a resident's caloric needs be provided and if a resident did not get the correct amount of feeding, it could result in weight loss, weakness, skin breakdown and malnourishment. If a resident was not getting the required water flushes weakness, dehydration, low blood pressure and abnormal labs could occur. 2) Resident #7 had diagnoses including adult failure to thrive, dementia with agitation, and hypothyroidism. The 7/18/2025 Minimum Data Set documented the resident had mildly impaired cognition, inattention and disorganized thinking, required set up for eating, and had significant weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss and was not on a physician-prescribed weight loss program. The 7/19/2025 Comprehensive Care Plan documented the resident had impaired nutrition and altered nutritional status related to significant weight loss with a past medical history of dementia, Parkinson's disease, constipation, and gastroesophageal reflux disease. Interventions included was to encourage intake of nutritional supplements between meals of Ensure Plus twice a day. The 8/13/2025 physician order documented Ensure Plus every day and evening shift to supplement the diet. The 9/9/2025 meal tickets for the breakfast, lunch, and dinner meal document the resident was lactose intolerant and was to receive an Ensure Clear Apple Supplement at every meal. The following weights were documented for Resident #7: - 137 pounds in March 2025; - there was no weight for April, May, and June 2025; - 118.8 pounds in July on the first weight and 117.4 pounds on the reweigh (14% loss in four months; - 106.8 pounds in August 2025 (9% loss in one month); - 106.8 pounds in September 2025. The 5/8/2025 Quarterly Nutrition Review from the resident's paper chart documented the resident received a regular consistency diet, had no new weight to assess, and they were unable to assess the resident's nutritional needs as there were no weights available for April and May 2025. The recommendation was continuing a regular diet with regular consistencies, offer snacks as needed, and monitor weights, intakes, skin, and labs. The 7/19/2025 Registered Dietitian #6 Quarterly Nutrition Assessment documented the resident was on a regular diet with thin liquids and was lactose intolerant. The resident had no chewing and swallowing issues and no skin breakdown. The resident had a weight change history of 13.28 % in one month and 14.53% in six months; had a fair appetite with meal intakes varying between 43-63%; and denied any changes to their meal profile. Due to the recent significant weight change, Ensure was recommended. The resident did not accept or decline the recommendation. Ensure was to be trialed twice a day to help improve calorie intakes. The resident's weight loss was due to an unknown etiology. The recommendations were to continue with a regular diet with regular consistencies and thin liquids, provide Ensure Plus twice a day, and continue to monitor the resident's weight, labs, and skin. There were no documented nutritional assessments for August 2025 or September 2025 to follow up on continued weight loss or effectiveness of nutritional interventions. During an observation and interview on 9/9/2025 from 12:49 PM to 1:07 PM, Resident #7's lunch tray was delivered by Certified Nurse Aide #17. Certified Nurse Aide #17 read off what was on the resident's tray which included: grilled cheese, apple juice, tomato soup, coffee, a cookie, and mixed berry Ensure Clear. The resident stated they could not have the grilled cheese and asked for an egg (continued on next page)

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Pontiac Nursing Home	303 East River Road Oswego, NY 13126

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	salad sandwich. The resident ate all the egg salad sandwich, three quarters of the tomato soup, and half of their coffee. The resident stated they did not like the clear apple Ensure and preferred the chocolate or strawberry Ensure. During an interview on 9/11/2025 at 10:51 AM, Certified Nurse Aide #28 stated weights were done once a month by the fifth and recorded in a binder at the nurses' station. If there was a weight loss or gain of five pounds or more, they should report it to the nurse. Resident #7 received Ensure every morning for breakfast and at lunch. The resident liked the lactose free milk Ensure strawberry or chocolate but did not like the clear liquid apple one and would not drink it. During an interview on 9/11/2025 at 12:25 PM, Certified Nurse Aide #17 stated Resident #7 preferred the chocolate or vanilla Ensure. They were unsure why the kitchen sent the clear apple or other fruit as the resident did not like it. During an interview on 9/11/2025 at 2:23 PM, Licensed Practical Nurse #5 stated weights were done at least monthly and recorded in a binder on the unit. If a weight was not collected, a progress note was put in for that resident. If a resident had a weight loss or gain, they should contact the provider, notify the dietitian, and add it to the 24-hour report. Resident #7 received clear Ensure on their tray and received an additional 237 milliliters twice a day that showed up on the Medication Administration Record. They did not know why the resident received the Ensure clear. If the resident refused their Ensure they reapproached and if they still refused, they should notify the nurse practitioner. During an interview on 9/12/2025 at 9:13 AM, Registered Nurse Supervisor #4 stated weights were done at least monthly on the first and recorded in the weight book at the nurses' station and in the electronic medical record. If a resident had a weight loss or gain, the dietitian was notified. They were unsure why Resident #7 was losing weight, and staff should encourage the resident to eat in the dining room or in the hallway. The resident received Ensure but they did not drink it. They were unaware the resident was receiving Ensure Clear instead of the Ensure Plus which was the resident's preference. The dietitian monitored the resident's continued weight loss. During an interview on 9/12/2025 at 11:41 AM, Registered Dietitian #6 stated they reviewed residents' nutritional status quarterly unless the resident was considered high risk then it was monthly. They stated they were only contracted to work at the facility six hours a week, so they tried to limit the monthly review list. When there was no weight for the previous two months to calculate a resident's nutritional needs, they followed up with the next month's weight and if there was no significant loss, they waited until the next quarter to reassess the resident. Weights were done by the fifth of the month and the reweighs were due two days after that. By mid-month they reviewed the residents for significant weight loss or gain of 5% or more. The 7/19/2025 review of Resident #7's weight loss from 137 in March of 2025 to 117.4 in July was delayed. They emailed the nursing staff to have Ensure added to the resident's orders. They did not follow up on the resident's weight in August 2025 even though the resident was down to 106 pounds. They stated they were on vacation for a significant portion of August and there was not sufficient coverage for the facility. They were currently reviewing the weights for August and September 2025. They stated they had not recommended Ensure clear for Resident #7; they had recommended Ensure Plus for the resident. They did not know why the resident was receiving Ensure clear as it should not have been on the resident's ticket without a physician's order, and the resident's physician order was for Ensure Plus. 10NYCRR415.12(i)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for one (1) of two (2) residents (Resident #48) reviewed. Specifically, Resident #48 received continuous positive airway pressure therapy (a machine used to keep the airway open by delivering continuous air through the nose) without a physician order with a supporting diagnosis, a plan to regularly clean the machine to prevent contamination, and a care plan for use of the device. Findings include: There was no documented evidence of a policy for positive airway pressure therapy. Manufacturers recommendations for maintenance of continuous positive airway pressure equipment included daily cleaning of the mask cushion and the humidifier tub (reservoir for placing water), and weekly cleaning of the tubing. Resident #48 had diagnoses including anxiety, depression, and trisomy (a genetic condition causing developmental delays, intellectual disabilities and various physical health problems). There was no documented diagnosis to support the use of a continuous positive airway pressure machine. The 7/29/2025 Minimum Data Set assessment documented the resident had severely impaired cognition and did not receive any respiratory treatments including continuous positive airway pressure treatments. The 7/22/2025 hospital discharge summary documented a diagnosis of drug induced syncope (fainting) with hypoxia (low oxygen levels). The was no documentation the resident required or used a continuous positive airway pressure machine. The Comprehensive Care Plan did not document the use of a continuous positive airway pressure machine.The 7/23/2025 Registered Nurse Supervisor #4 admission assessment documented the resident had a continuous positive airway pressure machine from the group home but there were no orders from the hospital for it. They would reach out to the group home for settings for the machine. There was no documented evidence of follow up by Registered Nurse Supervisor #4 regarding the resident's continuous positive airway pressure machine.The 7/31/2025 Medical Director's admission History and Physical did not document a diagnosis for, or include the use of, a continuous positive airway pressure machine. The 7/29/2025, 7/31/2025, 8/5/2025, 8/12/2025, 8/14/2025, 8/28/2025, 9/2/2025, 9/4/2025, and 9/9/2025 Nurse Practitioner #9's clinical encounter summaries did not document a supporting diagnosis for us of a continuous positive airway pressure machine. The 9/6/2025 Licensed Practical Nurse #10's progress note documented the resident was awake most of the night and was difficult to console, the continuous positive airway pressure machine was on with short term effects. The September 2025 vital sign summary documented the resident's oxygen saturation was measured while on a continuous positive airway pressure machine on 9/3/2025 at 12:56 AM, 9/4/2025 at 12:44 AM, 9/5/2025 at 2:47 AM, 9/6/2025 at 1:32 AM, and 9/9/2025 at 12:11 AM.There was no documented evidence of physician order for the use of a continuous positive airway pressure machine or an order for cleaning or maintaining the machine. During an observation on 9/8/2025 at 6:43 PM, Resident #43 was lying in bed with continuous positive airway pressure mask on their face, yelling out nonsensical speech in their room. Certified Nurse Aide #11 had just exited the resident's room and turned the light off. They stated the resident frequently yelled, and they just tried different things to see if they would stop. The resident's continuous positive airway pressure machine had just been applied and that usually helped. During an observation on 9/10/2025 at 10:07 AM, the resident was sleeping in their bed with the nasal mask on their face and the continuous positive airway pressure machine was on. It was a black machine on the nightstand with gray corrugated tubing, and the water reservoir tub was approximately half full. During an observation and interview on 9/11/2025 at 1:28 PM, Certified Nurse Aide #12 stated Resident #48 had a continuous positive airway pressure machine. They placed the mask and turned the power on. They also filled the water reservoir. They were not allowed to touch any of the other buttons/ knobs. The resident was sleeping in the bed, and the mask was on the floor. Certified Nurse Aide #12 picked up the mask and put it on top of the machine on the nightstand. The (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mask had brown stains on the gray fabric of the mask. Certified Nurse Aide #12 stated they were not sure if the mask or the tubing was ever cleaned. During a telephone interview on 9/11/2025 at 2:26 PM, Licensed Practical Nurse #10 stated continuous positive airway pressure machines were already programmed to settings from wherever the machine came from. They were used when the resident slept. The use of the machine required an order, and it was signed off in the medication administration record or the treatment administration record depending on how the order was entered. Resident #48 used the continuous positive airway pressure machine at night since admission even though they did not have an order for it. They told the oncoming nurses many times and put it in the 24-hour report that an order was needed. They could have called for an order on the night shift, but they had not as they did not like to make the medical providers mad. They did not know if the resident needed the machine, their oxygen saturations were good even when they refused to wear it. During an interview on 9/11/2025 at 3:56 PM, Licensed Practical Nurse #13 stated Resident #48 used a continuous positive airway pressure machine. They were responsible to ensure the mask was put on but often asked the certified nurse aides for help. They did not sign off Resident #48 had the machine. The resident did not have an order but should have, and it should include settings. Continuous positive airway pressure machines were a treatment, and all treatments required orders. The registered nurse supervisor was responsible to obtain the order when the resident was admitted . Licensed Practical Nurse #13 stated they were not responsible for cleaning clean the mask or the tubing. The sleep apnea (a condition when breathing repeatedly stops and starts during sleep) clinic was responsible for any maintenance of the machine. They stated the resident did not even have a diagnosis of sleep apnea for the machine.During an interview on 9/12/2025 at 9:55 AM, Registered Nurse Supervisor #4 stated Resident #48 did not use a continuous positive airway pressure machine. Use of a continuous positive airway pressure machine required a physician's order. They completed the resident's admission assessment and referenced their notes. They were not sure who brought the machine into the facility. They talked to the group home many times but never got the settings for the machine. The nurses should not be applying the machine without an order. If it was applied and they noted it was not on the record to be signed for, they should obtain an order. The resident did not have the ability to independently place the mask and needed help from staff. During a telephone interview on 9/12/2025 at 10:11 AM, Nurse Practitioner #9 stated they did not believe Resident #48 used a continuous positive airway pressure machine and they did not see an order for it. Nursing should not have applied the continuous positive airway pressure machine without an order. 10NYCRR 415.12(k)(6)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure residents were provided food and drink that was palatable and flavorful, and at an appetizing temperature for one (1) of two (2) meals reviewed (lunch meal on 9/9/2025). Specifically, the 9/9/2025 lunch meal entree was soft and had a soggy texture and the replacement entree was burnt. Findings include:There was no documented evidence of a food palatability or meal test tray policy. During an observation on 3/9/2025 at 12:38 PM, Resident #52's meal tray was tested, and a replacement tray was ordered. The grilled cheese sandwich was soft and had a soggy texture. At 12:43 PM, a replacement grilled cheese sandwich was provided to Resident #52. The sandwich was black in color on both sides, one side was darker than the other. During an interview on 9/12/2025 at 10:17 AM, [NAME] #27 stated they would not allow food to leave the kitchen if it did not look good. The burnt grilled cheese sandwiches should not have been served to the residents.During an interview on 9/12/2025 at 10:27 AM, the Food Service Director stated the grilled cheese sandwiches for the lunch meal on 3/9/2025 were grilled 45 minutes ahead of service. During the lunch service some of the sandwiches were dark in color and should have been switched out. Residents should not have been served burnt grilled cheese sandwiches. 10NYCRR 415.14(d)(2)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not provide specific services outside the facility when the facility did not employ a qualified professional to furnish the specific service for one (1) of one (1) resident (Resident #13) reviewed. Specifically, Resident #13 had a recommendation for an ankle-brachial index test (a test to diagnosis poor blood flow) that was not followed up in in a timely manner. Findings include:There was no documented evidence of an outside appointment/consult policy.Resident #13 had a diagnosis of diabetes and peripheral vascular disease (insufficient blood flow). The 8/5/2025 Minimum Data Set assessment documented the resident had intact cognition and two non-pressure related skin ulcers. The 7/29/2025 Comprehensive Care Plan, revised 9/10/2025, documented a wound management problem. Interventions included provide wound care per treatment order.The 7/29/2025 Registered Nurse Supervisor #4's clinical admission assessment documented a skin issue on both the left and right lower leg that were both likely cellulitis. The Wound Care Nurse Practitioner #20?s weekly wound notes documented the following:-on 8/4/2025 the skin on both lower legs was macerated with blue/green drainage noted; the resident stated they could not feel their legs; and a recommendation for an ankle-brachial index test prior to Unna boot application (a type of compression dressing).-on 8/18/2025 heavy drainage was noted, soaking through leg wraps as well as into shoes. The resident stated they could not feel their legs. Discussed need for ankle-brachial index with waveform prior to applying Unna boots due to unknown arterial/venous status.-on 8/25/2025 no ankle-brachial index test on file for review as requested at last visit. -on 9/1/2025 no ankle-brachial index on file for review/scheduled, requested at previous two visits. -on 9/9/2025 no ankle-brachial index on file for review/scheduled. Unna boot pending vascular workup.There was no documented evidence an ankle-brachial index was ordered or completed. During an interview on 9/11/2025 at 10:46 AM, Registered Nurse Supervisor #4 stated they uploaded Wound Nurse Practitioner #20's weekly notes, put a basic blurb of what they said in a progress note, put in the order, and then updated the care plan. If a consult was needed, they put the order in as a consult and gave it to the scheduler who then made the appointment and set up transportation. Resident #13's legs wept and dripped all over their room. Their wounds were vascular type wounds and were followed by the wound nurse since admission. The 8/26/2025 Registered Nurse Supervisor #4's skin/wound note documented no ankle-brachial index on file for review as requested at last visit.The 9/1/2025 Registered Nurse Supervisor #4's skin/wound note documented no ankle-brachial index on file for review/scheduled, requested at previous 2 visits.During a follow up interview on 9/11/2025 at 2:02 PM, Registered Nurse Supervisor #4 stated they read the weekly wound notes and implemented any recommendations. Resident #13 did not have an order for a vascular work up or an ankle-brachial index study and Wound Nurse Practitioner #20 had not been asked them about it. They did have an email from Wound Nurse Practitioner #20 on 9/1/2025 questioning whether ankle-brachial index had been done and the order for the ankle-brachial index test should have been implemented prior to 9/11/2025.During an interview on 9/12/2025 at 9:48 AM, Wound Nurse Practitioner #20 stated their weekly skin notes were automatically uploaded into the electronic medical record. They also sent an e mail of their findings and any recommendations, to various staff including the dietitian, the registered nurses, the supervisors, and the Director of Nurses. They saw Resident #13 for leg wounds. They believed they were venous related and wanted Unna boots for the resident since week one. They usually started with an ankle-brachial index test and then possibly a vascular work up prior to Unna boot usage. They reached out to the Director of Nurses and the Administrator about this not being followed up on and was told by the Administrator they did not get involved in clinical things. That was about a week ago. They expected when asking for a test it should be set up within a week. They considered this a delay in treatment because for the past few weeks they had been doing what (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they could for the resident rather than what they wanted to do. During an interview on 9/12/2025 at 11:57 AM, the Director of Nursing stated they did not know anything about Resident #13 needing an ankle-brachial index study. Registered Nurse #4 was responsible for following up on wound round recommendations. They received the weekly skin note email but was unable to see the recommendations. Wound Nurse Practitioner #20 spoke to them about difficulty getting what they requested but was not sure it was in regard to the ankle-brachial index study. 10NYCRR 415.26(e)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the recertification survey conducted 9/8/2025-9/12/2025 the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of two (2) residents (Resident #55) reviewed. Specifically, Resident #55 was on transmission-based precautions (contact precautions) and Housekeeper #22 cleaned Resident #55's room without wearing required personal protective equipment and did not perform appropriate hand hygiene upon leaving the room; and Certified Nurse Aide #23 provided care to Resident #55 without appropriate personal protective equipment or washing their hands upon leaving the resident's room. Findings include:The facility policy Isolation and Transmission Based Precautions, revised 12/2023 documented the facility would use standard precautions based on the Center for Disease Control guidelines in patient care areas. When there were reasons to believe a resident had a communicable infectious illness/disease, transmission-based precautions were to be initiated. Contact precautions were used with residents with suspected or known cases of illness that could be spread by contact with the resident or indirect contact with items in the resident's environment. A physician's order was necessary to implement and discontinue contact precautions. The resident on contact precautions would be placed in a private room if possible. Clean gloves and a disposable gown were to be worn when entering the room and the removal of the gown and gloves along with hand hygiene were to be performed prior to exiting the room. Resident #55 had diagnoses including gastrostomy (feeding tube) and a chronic back ulcer.The 9/9/2025 physician's order documented the resident was on contact precautions for shingles. During an observation and interview on 9/9/2025 at 12:59 PM, Housekeeper #22 was sweeping the floor in Resident #55's room and was not wearing a gown or gloves and did not perform hand hygiene prior to exiting the resident's room. Housekeeper #22 stated they were unsure if they should wear a gown or gloves in Resident #55's room. They stated they read the transmission-based precaution signs posted outside the resident's room and they should have worn a gown and gloves. They did not see the sign on the wall next to the door when they entered the room. During an observation and interview on 9/09/2025 at1:02 PM Certified Nurse Aide #23 entered the resident's room and was not wearing a gown or gloves. Certified Nurse Aide #24 reminded Certified Nurse Aide #23 they were in a contact precaution room with no personal protective equipment on and provided ice to the resident. Certified Nurse Aide #23 exited the room without performing hand hygiene. Certified Nurse Aide #23 stated they were supposed to wear a gown and gloves in a contact precaution room. The resident had just moved to that end of the hallway, and the room was previously empty. They did not see the contact precaution sign when they had entered the room to answer the resident's call light. During an interview on 9/12/2025 at 9:13 AM, Registered Nurse Supervisor #4 stated staff knew what precautions a resident was on by their Kardex and by the posting on the wall in their office. Staff should wear a gown and gloves in a room with contact precautions. Resident #55 was on contact precautions for shingles, and staff should wear a gown and gloves every time they entered the room. They educated the staff and the resident's family. During a phone interview on 9/12/2025 at 12:31 PM Registered Nurse Supervisor/Infection Control Nurse #8 stated when a resident was on contact precautions the facility put the resident on isolation with a cart and a transmission-based precaution sign. They informed family members who visited and educated them. The staff was educated on an ongoing basis for enhanced barrier precautions. They followed up occasionally with resident specific education regarding precautions with the floor nurses who then educated the certified nurse aides. Staff should wear gowns and gloves into the resident's room and sanitize their hands prior to exiting. 10NYCRR 415.19(a)(b)

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F 0638 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interviews during the recertification survey conducted 9/8/2025-9/12/2025, the facility did not ensure they assessed residents using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services not less frequently than once every three months for two (2) of four (4) residents (Residents #25 and #52) reviewed. Specifically, Residents #25's and #52's Minimum Data Set assessments were completed later than 14 days after the Assessment Reference Date (the final day of the observation period to gather information about a resident's condition when completing the assessment).Findings include: There was no documented evidence of a Minimum Data Set assessment policy.Resident #52's Minimum Data Set assessment documented an Assessment Reference Date of 5/10/2025 and was not completed. Resident #25's Minimum Data Set assessment documented an Assessment Reference Date of 5/5/2025 and was not completed.During a telephone interview on 9/11/2025 at 1:54 PM, Minimum Data Set Coordinator #16 stated they kept track of the Minimum Data Set assessment schedule on a spreadsheet, but the facility just transitioned to a new electronic system, so they were still using both. They stated they were not at the facility and was not able to access the electronic system until later that day. They thought the Director of Nursing had access to the Minimum Data Set assessment schedule.During an interview on 9/11/2025 at 1:59 PM, the Director of Nursing stated Resident #52's and #25's quarterly Minimum Data Set assessments were overdue, and they should have been completed in early August 2025. They did not complete the Minimum Data Set assessments, so they were not sure why they were not completed. They thought they could have been missed when the facility transitioned to the new electronic system. 10NYCRR 415.11(a)(4)