STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335645	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Nursing Home & Health Related Facility Inc	3005 Watkins Road Horseheads, NY 14845

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49447 Based on observations, interviews, and record review conducted during the Recertification Survey from 03/17/2025 to 03/21/2025, the facility did not ensure that all residents had the right to request, refuse, and/or discontinue treatment, and to formulate an advance directive (a resident's preferences for medical interventions in the event of a life-threatening episode) that would be honored for one (1) (Residents #89) of 32 residents reviewed for advanced directives. Specifically, the facility did not ensure that Resident #89's advanced directives preferences were consistently identified. This is evidenced by the following: The facility policy Advanced Directives, last reviewed May 2025, included it is the policy of the facility to honor the advance directives of all residents and if no advance directives are available and the resident or family have not stated their wishes to execute an advance directive, the resident will be designated as full code status (attempt cardiopulmonary resuscitation in the event of cardiac or respiratory arrest). 1. Resident #89 had diagnoses that included Parkinson's disease, diabetes, and high blood pressure. The Minimum Data Set (a resident assessment tool), dated 03/11/2025, included the resident was cognitively intact. During an interview on 03/17/2025 at 11:41 AM, Licensed Practical Nurse #1 stated the resident's name tag (outside the residents' rooms) is colored blue which indicated the resident was a full code and a white colored name tag means the resident is a DNR (do not resuscitate meaning cardiopulmonary resuscitation would not be started if the heart or breathing ceases). Licensed Practical Nurse #1 stated they use the name tag indicator in an emergency to know if a resident was a full code or a DNR. During an observation on 03/17/2025 at 3:01 PM, Resident #89's name was printed on a blue name tag (indicating their wishes for full code) on the wall next to the resident's door to their room. Review of Resident #89's electronic health record revealed a Medical Order for Life Sustaining Treatment (also known as a MOLST) signed by Nurse Practitioner #1 on 12/05/2025 that included wishes for DNR or to not be resuscitated in the event of an acute medical episode. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current physician's orders, dated 12/05/2025, included the resident had an advanced directives that included wishes were for DNR and do not intubate (insert a tube into the windpipe to assist with breathing). During an interview on 03/18/2025 at 2:38 PM, Licensed Practical Nurse #2 stated they would use the door tag indicator for code status in an emergency to see if a resident was a full code or not and check the Medical Order for Life Sustaining Treatment. They stated if they found a discrepancy they would treat the resident as a full code and start cardiopulmonary resuscitation. Licensed Practical Nurse #2 stated they had identified discrepancies between name tags, physician's orders, and Medical Order for Life Sustaining treatment forms in the past. During an interview on 03/18/2025 at 3:07 PM with Unit Clerk #1 and Registered Nurse Manager #1, Unit Clerk #1 stated they were responsible for placing and updating the name tags if code status changes. They stated they placed a blue name tag for Resident #89 when they were admitted because they did not have a Medical Order for Life Sustaining Treatment but did not update it when Resident #89 became a DNR. Registered Nurse Manager #1 stated Resident #89 had a blue name tag on their door, but it should have been white. They stated that if the code status indicators (name tag, physician's order, and Medical Order for Life Sustaining Treatment) did not match it would cause confusion and a resident's wishes for life staining treatment may not be followed. During an interview on 3/18/2025 at 3:28 PM, the Director of Nursing stated all code status indicators should match, and nursing staff should confirm residents' code status in the electronic health record and not use the door indicator alone. If there is a discrepancy, nursing staff should go by the Medical Order for Life Sustaining Treatment. 10 NYCRR 415.3(f)(1)(ii)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49447 Based on record review and interviews conducted during the Recertification Survey from 03/17/2025 to 03/21/2025 for seven (Resident #2, #8, #50, #54, #66, #86, and #96) of 32 residents reviewed, the facility did not ensure the Minimum Data Set Resident Assessment (an assessment tool) accurately reflected the residents' status. Specifically, the issues involved inaccurate coding for Section A - Identification Information (Resident #96) and Section N - Medications (Resident #2, #8, #50, #54, #66, and #86). This is evidenced by, but not limited to, the following: The facility policy Resident Assessment Instrument Minimum Data Set, last reviewed September 2016, included the facility must complete an accurate, standardized, reproducible assessment of each resident's care problems on admission and periodically thereafter. 1. Resident #96 had diagnoses that included heart failure, kidney disease, and high blood pressure. The Minimum Data Set Discharge Assessment (a resident assessment tool) dated 02/13/2025, documented Resident #96 was cognitively intact and was discharged from the facility to the hospital. In a progress note, dated 02/13/2025, Registered Nurse #1 documented Resident #96 was discharged home with family and community services. During an interview on 03/20/2025 at 2:31 PM, the Minimum Data Set Coordinator stated Resident #96 was discharged to the community, not the hospital, and the Minimum Data Set was not coded correctly. 2. Resident #2 had diagnoses that included heart failure, diabetes, and chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing breathing problems). The Minimum Data Set, dated dated dated [DATE], documented Resident #2 had moderate impairment of cognitive function and was receiving an anticoagulant (blood thinner to prevent blood clots) medication. Review of physician's orders, effective 01/29/2025 (at the time of the resident assessment), revealed aspirin 81 milligrams once daily initially ordered 04/19/2022. There were no orders for any anticoagulant medications for the time period identified. 3. Resident #50 had diagnoses that included high blood pressure and coronary artery disease (decreased blood flow to the heart caused by blocked or narrowed arteries). The Minimum Data Set, dated dated dated [DATE], documented Resident #50 had severe cognitive impairment and was receiving an anticoagulant medication. Review of the physician's orders at the time of the resident assessment revealed an order for aspirin 81 milligrams once daily, dated 05/18/2021, and no orders for an anticoagulant medication in the time period. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 03/19/2025 at 1:08 PM, the Minimum Data Set Coordinator stated they were responsible for completing sections A and I and ensuring accuracy of the information documented in the Minimum Data Set Resident Assessments. They stated they had been documenting aspirin as an anticoagulant in the resident assessments and did not know that aspirin should not be documented as an anticoagulant. During an interview on 03/20/2025 at 2:39 PM, the Director of Nursing stated the Minimum Data Set Assessments should be accurate, medications should be documented per the Resident Assessment Instrument manual, and aspirin should not be documented as an anticoagulant. They stated resident assessments should be accurate to ensure residents are receiving the care and services they need. During an interview on 03/21/2025 at 11:00 AM with the Administrator and Director of Nursing, the Administrator stated they had been aware of some discrepancies in the Minimum Data Set Assessments, but had not identified discrepancies specific to medications and discharge information. 10 NYCRR 415.11(b)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49447 Based on observations, interviews, and record reviews conducted during a Recertification Survey from 03/17/2025 to 03/21/2025, the facility did not ensure the daily nurse staffing information was updated on a daily basis. Specifically, the nurse staffing information was not posted daily at the beginning of each shift during the survey, and the information on the form was not updated to reveal current dates and staffing changes. This is evidenced by the following: The undated Daily Nurse Staffing Data Protocol documented: The Scheduling Coordinator is responsible Monday to Friday for ensuring the nurse staffing data is posted in the lobby daily. In the nurse scheduler's absence, Medical Records staff or Skill 2 Unit Manager will post the staffing data. This will be completed as close to 7:00 AM as possible. On weekends and holidays, the Registered Nurse Supervisor will post the nurse staffing data close to 7:00 AM. This responsibility will be reviewed during any new Registered Nurse Supervisor orientation. During observations on 03/17/2025 at 10:03 AM, the nurse staffing information was posted at the main entrance and was dated 03/14/2025. At 4:15 PM on that same day, the nurse staffing information was dated 03/15/2025. During an observation on 03/18/2025 at 8:05 AM, the nurse staffing information remained dated 03/15/2025. During an interview on 03/20/2025 at 11:40 AM, Unit Clerk #1 stated they completed the nurse staffing information in the morning Monday through Friday. On weekends, the supervisor was responsible for updating and posting the nurse staffing information. Unit Clerk #1 stated they usually updated the nurse staffing information between 8:00 AM and 8:30 AM each morning, but they were sometimes behind and did not get it posted until 9:30 AM or 10:00 AM. They stated it had not been brought to their attention that the nurse staffing information was not being updated regularly on the weekends. During an interview on 03/20/2025 at 3:33 PM, the Director of Nursing stated it was Unit Clerk #1 and the weekend supervisor's responsibility to update the nurse staffing information and that the information should be posted daily on the day shift after receiving morning report. Additionally, the Director of Nursing stated there were some newly hired supervisors who had not been trained and that it had not been brought to their attention that the nurse staffing information was not being updated daily. The Director of Nursing stated there was a breakdown in their process, and they needed to train new staff and retrain their current staff. 10 NYCRR 415.13