STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335658	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groton Community Health Care Ctr Res Care Fac	120 Sykes Street Groton, NY 13073

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49448 Based on interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure residents exercised their rights as a citizen or resident of the United States for 70 of 70 residents residing in the facility. Specifically, mail was not delivered to residents on Saturdays, thereby denying all residents the same rights provided to other citizens and residents of the community. Additionally, 2 of 5 anonymous residents present at the resident group meeting stated their mail was opened prior to it being delivered to them. Findings include: The facility policy, Mail and Electronic Communication (Residents), dated 5/19/2021, documented residents received their mail promptly and unopened unless requested in writing by the resident or designated representative. Mail was received and sorted by the receptionist. Mail and packages were delivered by the activity staff to the resident within twenty-four hours of delivery on premises and included Saturday deliveries. The undated facility policy, Resident Rights, documented residents had a right to access mail. The nursing facility ensured residents had the right to exercise their rights without interference from the facility. During a resident group interview on 11/21/2024 at 2:23 PM, 5 of 5 anonymous residents stated mail was not delivered to them on Saturdays because the activities department did not work on Saturdays. Two residents stated they received mail that was opened prior to it being delivered to them. One resident stated they had a package that was delivered to the facility at 3:31 PM on a Saturday per the tracking information and it was not received until 8:00 AM the following Monday. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/3/2024 at 8:41 AM, Administrative Assistant #28 stated they picked up the white box the mail goes in from the front entrance after it was delivered. There was a spreadsheet on the shared drive that instructed whether a resident got their own mail or if their designated representative received their mail based upon preferences and cognitive scores. If the preference was for the mail to be forwarded to a designated representative, they took care of that. They were responsible for sorting the mail. Any newspapers, magazines, or packages went in the Director of Activities' mailbox for delivery. All other mail went into the Nursing Unit Coordinator's mailbox for delivery. They did not work on weekends. On Saturdays, the housekeeping staff placed the white mailbox in the mail room so it did not sit in the front entrance all weekend. When they returned to work on Monday, they sorted the mail. They never opened any mail. During an interview on 12/3/2024 at 9:32 AM, Nursing Unit Coordinator #29 stated they checked their mailbox throughout the day for resident mail. They followed the list on the shared drive to determine if mail went straight to the resident or if it went to a designated representative. If the resident received their own mail, they took it directly to them. If a designated representative received the mail, it went into a lock box until that person visited. Mail was never delivered opened and was only opened in the resident's presence if they requested. They did not work weekends and was unaware if residents received mail on weekends. On Monday morning they checked their mailbox for resident mail. This had been the process since June 2023 when they started delivering residents' mail. During an interview on 12/3/2024 at 10:11 AM, the Director of Activities stated Administrative Assistant #28 usually called them after they placed resident mail in their mailbox. They delivered the newspapers and cards to the residents during the week, but they did not work on the weekends. Residents should get their mail when it was delivered, there was no reason why they should not. They got mail at home on Saturdays so the residents should too. Residents told them before they had mail delivered opened. During an interview on 12/4/2024 at 8:38 AM, Housekeeper #25 stated they had worked for the facility for the past 2 years and worked every other weekend. On Saturdays, they brought the mail in and placed the box of mail on Administrative Assistant #28's desk. During an interview on 12/4/2024 at 11:39 AM, the Administrator stated the facility received mail on Saturdays. They were aware residents received opened mail, but all mail should be received unopened. If it looked like a bill, it was often opened to ensure it was paid. They explained to staff that if mail looked like a bill, it should be taken to the finance department to be opened with the resident and explained to them. Residents should receive mail timely or they might not get a birthday card until after their birthday. Residents had the right to receive mail promptly and unopened as it violated the residents' privacy if it was opened. 10NYCRR 415.3(d)(2)(i)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48895 Based on record review, observations, and interviews during the recertification and abbreviated (NY00359606) surveys conducted 11/7/2024-12/4/2024, the facility did not ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 2 nursing units. Specifically, there was no hot water in the facility from 10/29/2024-11/8/2024. Additionally, resident's or resident representatives were not immediatley notified of the lack of hot water. Findings include: The undated facility policy, Safety of Water Temperatures, documented tap water in the facility should be kept within a temperature range to prevent scalding of residents. Water heaters that serviced resident rooms, bathrooms, common areas, and tub/shower areas were set at temperatures of no less than 105 degrees Fahrenheit and no more than 120 degrees Fahrenheit. Maintenance staff conducted daily tap water temperature checks using a calibrated digital thermometer at various locations in the facility and recorded the water temperatures in a safety log. If water temperatures fell outside the specified range, the maintenance department adjusted the water heating or cooling system as necessary and rechecked the temperatures. The October 2024 and November 2024 water temperature logs documented the following temperatures at each of the four tested sites (Unit-1 dining room, Unit-1 north shower room, Unit-2 North shower room, Unit-2 dining room): - on 10/1/2024-10/28/2024 - all temperatures were documented between 117 and 133 degrees Fahrenheit - on 10/29/2024 97 degrees Fahrenheit, 96 degrees Fahrenheit, 96 degrees Fahrenheit, 95 degrees Fahrenheit - on 10/30/2024 75 degrees Fahrenheit, 75 degrees Fahrenheit, 76 degrees Fahrenheit, 75 degrees Fahrenheit - on 10/31/2024 75 degrees Fahrenheit, 75 degrees Fahrenheit, 75 degrees Fahrenheit, 76 degrees Fahrenheit - on 11/1/2024 76 degrees Fahrenheit, 76 degrees Fahrenheit, 75 degrees Fahrenheit, 76 degrees Fahrenheit - on 11/2/2024 no recorded temperatures - on 11/3/2024 no recorded temperatures - on 11/4/2024 73 degrees Fahrenheit, 74 degrees Fahrenheit, 75 degrees Fahrenheit, 74 degrees Fahrenheit (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- on 11/5/2024 73 degrees Fahrenheit, 75 degrees Fahrenheit, 74 degrees Fahrenheit, 73 degrees Fahrenheit - on 11/6/2024 73 degrees Fahrenheit, 74 degrees Fahrenheit, 75 degrees Fahrenheit, 74 degrees Fahrenheit - on 11/7/2024 73 degrees Fahrenheit, 74 degrees Fahrenheit, 73 degrees Fahrenheit, 73 degrees Fahrenheit - on 11/8/2024 127 degrees Fahrenheit, 124 degrees Fahrenheit, 123 degrees Fahrenheit, 126 degrees Fahrenheit (after new pump installation) During an observation on 11/7/2024 at 12:22 PM, a cooler of water was on the counter at the nurse's station on Unit-1 and the water was measured at 96 degrees Fahrenheit. There were wiping clothes next to the cooler. During an interview on 11/7/2024 at 12:34 PM, Registered Nurse #21 stated the cooler was used for incontinence care and a bath in a bag (a no-rinse, disposable bathing system) was used for providing bed baths to residents. Staff were trained on how to administer the bath in a bag product. The facility's in-service sign in sheets for the bath in a bag procedure documented each unit had been trained on the procedure on 11/7/2024 (approximately 2 weeks after low water temperatures were identified) and was signed by Certified Nurse Aide #44 and Certified Nurse Aide #45. During an interview on 11/7/2024 at 12:49 PM, Certified Nurse Aide #44 stated they were using wash cloths from the cooler to bathe residents prior to this morning when they received the bath in a bag product. They stated some residents were not happy they could not shower in the shower room. During an interview on 11/7/2024 at 12:55 PM, Certified Nurse Aide #45 stated they were using wipes that were warmed in the microwave to wash residents. They were not sure why this product was only available starting 11/7/2027 since the facility had been without hot water since 10/30/2024. Before this they only had the cooler at the nurse's station and a washcloth. They stated residents were not happy they were not being showered because of the lack of hot water and staff were trying to use shower caps so at least the resident's hair was washed. During an observation and interview on 11/7/2024 at 1:32 PM, Maintenance Technician #9 stated they checked the water temperature in the building first thing in the morning with a probe thermometer. They checked the first-floor bathroom outside the dining room, then the small shower room on Unit-1, then the small shower room on Unit-2, and finally the Unit-2 dining room. They stated they were looking for temperatures from 90-120 degrees Fahrenheit and if they were out of range, they notified the Maintenance Director. The temperatures on 10/29/2024 were lower than normal and they notified the Maintenance Director. The stated their vendor came on site on 10/29/2024 and identified a water pump was broken and was supposed to be fixed, but the vendor had not shown up yet. The Unit-1 dining room water temperatures were measured with Maintenance Technician #9. The surveyor measured 74.7 degrees Fahrenheit, and the maintenance technician measured 73.3 degrees Fahrenheit with their thermometer. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/7/2024 at 1:49 PM Resident #20 stated they did not have hot water. They stated they were informed about the issue when the facility announced that residents would not get showers for the week. They stated they were not happy with the situation and would rather shower with cold water than be washed in bed with wash cloths. During an interview on 11/7/2024 at 1:58 PM, Resident #61 stated they did not have hot water for 2 weeks and needed it now. They were told there was no hot water because the facility needed parts. They stated they would love to have a hot shower. During an interview on 11/7/2024 at 2:54 PM, the Assistant Director of Nursing #20 stated residents were informed about the lack of hot water and were upset about the food being served on paper plates. They were not sure if families were notified there was no hot water in the facility. They stated the bath in a bag product could be warmed in the microwave was purchased because of the lack of hot water. They stated the repair was taking so long because it was a specialty part that had to come from Buffalo. During an interview 11/7/2024 at 3:08 PM Director of Nursing #2 stated they received the bath in a bag product on 11/6/2024. Prior to receiving the bath in a bag, they were using disposable wipes and wash cloths that were observed in the coolers on the units. Residents were notified about the lack of hot water when personal hygiene was provided, and some were not happy because they wanted a hot shower. They were not sure why it was taking so long to fix; the Maintenance Director was not working this week and they were the one to follow up with regarding the part, delivery, and installment when they returned. They did not believe families were officially notified about the lack of hot water and they should have been. During an interview on 11/7/2024 at 3:16 PM, the Administrator stated they recently started using bath in a bag as an alternative option for a regular shower due to the lack of hot water in the facility. Residents were told by staff about the loss of hot water as they gave care, and no official announcement was made. Initially the repair was going to take 3-5 days, and only one resident family came to them to discuss the lack of hot water. Families were not notified about the lack of hot water. They stated the residents were only supposed to get a shower once a week so they did not think it was that much of an inconvenience, but they would not like to go 10 days without a hot shower. They did not notify the Department of Health because they never lost water, they just did not have hot water. The Administrator stated the repair was taking longer to fix than expected because the contractor only had one pump available. An email correspondence between the Administrator, the Maintenance Director, and their vendor documented the following: - on 10/29/2024 at 4:50 PM, a quote for the repair was provided to the facility. - on 10/29/2024 at 5:46 PM, the Administrator asked the Director of Maintenance if the pump was replaced today. - on 10/30/2024 at 5:30 AM, the Director of Maintenance stated the vendor needed a part, one was available in Rochester, and the vendor would go get that for a fee or it would not get fixed until Friday (11/1). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- on 11/4/2024 at 4:05 PM, the vendor replied they were sorry for the delay, but there was an issue with their payment. - on 11/5/2024 at 8:53 AM, Director of Finance #55 replied that the issue with payment was due to the credit card having been maxed out again. 10 NYCRR 415.29 (f)(6), (j)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 48446 48895 49448 Based on observations, record review, and interviews during the recertification and abbreviated (NY00356968) surveys conducted 11/21/2024-12/4/2024, the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 3 of 3 residents (Resident #16, #17, and #30) reviewed; and for 1 of 2 emergency carts (Second Floor dining room emergency cart) reviewed. Specifically, the emergency cart in the dining room on the Second Floor was not checked daily to ensure emergency supplies were available; Resident #30 had a discontinued anti-fungal cream administered by Certified Nurse Aide #34; Resident #16 had three separate orders for as needed acetaminophen (Tylenol, pain reliever/fever reducer); and Resident #17 had two orders for as needed acetaminophen, and Percocet (an opioid pain medication) was administered outside of ordered pain parameters. Findings include: The facility policy, Medication Management, effective 8/2020, documented the facility provided medication management that optimized the therapeutic benefit of medication therapy and minimized or prevented potential adverse consequences. The facility, the attending physician/prescriber, and the consultant pharmacist performed ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisciplinary team participated in the care process and identified, assessed, addressed, advocated for, monitored, and communicated the resident's needs and changes in condition. The facility policy, Pain Assessment and Management Policy, revised 1/20/2009, documented each resident was assessed for pain on admission and on a quarterly basis, significant changes in residents' condition, or when verbal and non-verbal responses indicated the resident may be in pain. Once a resident was identified as needing pain management intervention, an individual program was developed for that resident. When writing an order for pharmacological pain control, the order included the pain intensity based on the resident's perception of their pain and the pain scale tools. For a scale of 1-3 was mild pain, 4-7 was moderate pain, and 8-10 was severe pain. The facility policy, Emergency Cart, effective 4/13/2021, documented the facility kept the emergency cart on each unit properly stocked and maintained. The cart was stored in each dining room on both units. The cart was checked daily for cart tag, back board (used as a hard surface when performing cardiopulmonary resuscitation) and oxygen tank by the day shift licensed practical nurse or registered nurse and the log was signed. EMERGENCY CART: During an observation on 11/26/2024 at 1:08 PM, the Second Floor emergency cart was in the dining room. The top of the cart had a September 2024- November 2024 Checklist. There was no documented evidence the cart was checked on the following days: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/1/2024, 9/6/2024, 9/7/2024, and 9/15/2024 through 9/30/2024. - 10/1/2024, 10/3/2024, 10/4/2024, 10/10/2024, 10/11/2024, and 10/27/2024. - 11/10/2024, 11/16/2024, 11/17/2024. During an observation on 12/2/2024 at 2:17 PM, the Second Floor emergency cart was in the dining room. The top of the cart had a September 2024- November 2024 Checklist. There was no documented evidence the cart was checked on the following days: - 11/28/2024, 11/30/2024, and 12/1/2024. During an interview on 12/3/2024 at 11:18 AM, Licensed Practical Nurse #35 stated the emergency cart was checked daily by Licensed Practical Nurse Assistant Unit Manager #38. After they reviewed the logs located on top of the cart, they stated the cart was not checked daily. It was important the cart was checked to make sure all the supplies were there in the event of an emergency. During an interview on 12/3/2024 at 11:58 AM, Licensed Practical Nurse #13 stated the emergency cart was checked daily by the nurses, but the Licensed Practical Nurse Assistant Unit Manager #38 usually did it. The day shift nurses were responsible to ensure the cart was checked. This was not assigned to any specific nurse and sometimes the night shift nurse checked the cart. If the cart was not routinely checked, it might not have the supplies needed in an emergency. During an interview on 12/4/2024 at 9:08 AM, Licensed Practical Nurse Assistant Unit Manager #38 stated the emergency cart was everyone's responsibility. The day nurses checked the cart at breakfast time, but it was not assigned to a specific nurse. The cart was supposed to be checked daily. If it was not checked daily, the needed supplies may not be in the cart during an emergency. They usually checked the cart when they arrived on the unit and there were times it was not checked. During an interview on 12/4/2024 at 9:28 AM, the Registered Nurse Unit Manager #14 stated the emergency cart was checked daily by the overnight nurse. There was only one nurse on the overnight and then either themselves or the Licensed Practical Nurse Assistant Unit Manger #38 checked it in the morning. On the weekends, it was probably not being done, this had been an issue. If the emergency cart was not being checked daily, education needed to be done. If it was not being checked, emergency supplies may be missing, and which could cause harm or delay in care during an emergency. MEDICATION ORDERS 1) Resident #30 had diagnoses including dementia. The 9/27/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required maximum assistance with most activities of daily living, and received application of ointment other than to feet. A physician order dated 2/15/2024 documented Miconazole nitrate external ointment 2% (anti-fungal medication) apply to gluteal/buttocks, groin, and abdomen every day and night shift for fungal rash for 14 days. The order was discontinued on 2/29/2024. The Comprehensive Care plan did not include an active fungal rash of the buttocks, groin, and abdomen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The December 2024 Medication Administration and Treatment Administration Records did not include the use of Miconazole nitrate external ointment. During an observation on 12/3/2024 at 11:15 AM, the resident was lying in bed. Certified Nurse Aide #34 entered the room and removed the top linens to perform care. The resident had an incontinence brief on and was lying on an incontinence pad. The resident's groin and the back of their thighs had a bright red rash that extended up to their lower back. Certified Nurse Aide #34 washed the resident's groin and buttocks and applied 2% Miconazole cream to those areas. During an interview on 12/3/2024 at 11:36 AM, Certified Nurse Aide #34 stated the resident had a big, red rash and looked like they had been wet for quite some time. They did not know the name of the cream they applied to the resident. They should not apply medicated creams as they were not certified to do so. If the wrong cream was applied, it could cause the area to get worse or cause an allergic reaction. During an interview on 12/3/2024 at 11:54 AM, Licensed Practical Nurse #35 stated Resident #30 had on going skin issues. Miconazole cream was discontinued and should not have been applied. Nurse aides should not have applied any medicated creams because they did not know what the orders were. If the wrong treatment was applied, the resident could develop burning and redness. During an interview on 12/3/2024 at 12:17 PM and 1:16 PM, Registered Nurse #21 stated certified nurse aides should not apply medicated creams and if the wrong cream was applied it could result in an infection or even cause a new skin issue. The resident had a chronic rash, and the current treatment did not include Miconazole 2% cream and it should not have been applied. During an interview on 12/3/2024 at 1:55 PM, The Director of Nursing stated Resident #30 should not have received Miconazole 2% cream as the application of wrong creams could be toxic and make the issue worse. 2) Resident #16 had diagnoses including Parkinson's disease (a progressive neurological disorder), morbid obesity, and sepsis (infection in the blood). The 9/21/2024 Minimum Data Set assessment documented the resident was cognitively intact, did not have pain, and did not receive pain medication. The Comprehensive Care Plan initiated 9/14/2024 documented the resident had pain related to Parkinson's disease. Interventions included pain was monitored and medications were given as needed. Physician orders documented: - on 3/27/2024 acetaminophen 325 milligrams, give two tablets by mouth every 4 hours as needed for pain-mild. - on 4/5/2024 acetaminophen 500 milligrams, give one tablet by mouth every 4 hours as needed for oral pain. - on 9/17/2024 acetaminophen 500 milligrams, give one tablet by mouth every 4 hours as needed for pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/2/2024 monthly medication review completed by Pharmacist #37 documented Resident #16 had three separate orders for administration of acetaminophen when needed. They recommended physician re-evaluation for necessity of all three orders to eliminate confusion or repeated administration. The Medical Director/ Attending Physician documented a response acetaminophen 500 milligrams one tablet by mouth every 4 hours as needed for oral pain and acetaminophen 650 milligrams by mouth every 4 hours as needed for pain-mild was discontinued. They documented the acetaminophen 500 milligrams by mouth every 4 hours as needed for pain was to be kept. The 10/2024 Medication Administration Record documented: - acetaminophen 500 milligram tablet, give 1 tablet every 4 hours as needed for oral pain with a start date of 4/5/2024 and a discontinue date of 11/29/2024. - acetaminophen 500 milligram tablet, five 500 milligrams by mouth every 4 hours as needed for pain with a start date of 9/17/2024 and a discontinue date of 11/29/2024. - acetaminophen 325 milligrams, give 2 tablets by mouth every 4 hours as needed for mild pain with a start date of 3/27/2024 and a discontinue date of 11/29/2024. There was no documentation of a maximum daily dose for the acetaminophen. The acetaminophen was not administered in 11/2024. During an interview on 11/25/2024 at 11:55 AM, Pharmacist #37 stated they recommended one acetaminophen order at the monthly medication review on 10/2/2024 to eliminate confusion with three orders and eliminate the potential for repeated administration. They followed up on the order on 11/4/2024 and stated although the Medical Director/ Attending Physician agreed with the recommendation on 10/2/2024, it was not documented accurately in the medical record. If there were duplicate orders in the medical record a resident could get too much medication which was a safety concern. During an interview on 11/29/2024 at 12:54 PM, Licensed Practical Nurse Assistant Unit Manager #16 stated when a resident was admitted to the facility the interdisciplinary team reviewed medications for accuracy and appropriateness. When a resident was admitted to the hospital and returned to the facility, the admitting nurse reviewed the hospital discharge medications and compared them to the previous facility medication list and ensured medications were not missed or duplicated. Facility medications prior to the hospitalization were discontinued when the resident was admitted to the hospital or put on hold if they were just being evaluated in the emergency room . They stated there should not have been duplicate orders for medications unless the resident received a medication more than once a day and had two different dosages. It was the administering nurse's responsibility to ensure there were not duplicate orders for the same medication. They were unsure what could happen to a resident if they received multiple doses of a duplicate medication and stated it depended on the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/2024 at 12:52 PM, the Assistant Director of Nursing #20 stated medications were reviewed with every physician visit. It was important medications were reviewed when a resident returned from the hospital because there may have been a change in the medication, or the medication could have been discontinued. If there were duplicate orders for the same medication, the resident received the newest order as the electronic record used by the facility did not block out the duplicate orders and allowed those orders to be administered. They were notified on 11/29/2024 by Pharmacist #37 about the duplicate acetaminophen orders for Resident #16 and immediately had them discontinued. They should have been discontinued on 10/2/2024 when recommended by Pharmacist #37 and agreed upon by the Medical Director/ Attending Physician. During an interview on 12/4/2024 at 9:40 AM, Licensed Practical Nurse Assistant Unit Manager #16 stated the monthly medication review process was broken down on their unit. Normally, the monthly medication review paperwork was reviewed and initialed by Licensed Practical Nurse Assistant Unit Manager #16 before it was given to the unit clerk and scanned into the electronic record. The monthly medication review completed on 10/2/2024 for Resident #16 was not initialed, therefore, it was not seen. If orders were not documented properly, it could be a safety concern for the resident. 3) Resident #17 had diagnoses including chronic pain. The 9/17/2024 Minimum Data Set assessment documented the resident was cognitively intact, had medically complex conditions, received a scheduled pain medication regimen, and received as needed pain medications or they were offered and declined. The Comprehensive Care Plan initiated 7/12/2024 documented the resident was at risk for pain related to depression, disease process, diabetes mellitus, chronic pain, and weakness. Approaches included administer analgesia (pain medication) as per orders. The 9/13/2024 Pharmacist #37 monthly medication review note to Medical Director/Attending Physician documented the resident had several as needed medication orders for similar indications without instructions as to a sequence in which these options should be offered for administration. There were orders for acetaminophen as needed and oxycodone with acetaminophen as needed. On two separate administrations during September, Percocet (oxycodone with acetaminophen) was given with a reported pain of 0 and 3 and was given at least once daily throughout the month. Recommendations included the orders were clarified as to which should be given when using a pain scale or it should be considered that one of them was discontinued. The 9/18/2024 Medical Director/Attending Physician response documented Tylenol (acetaminophen) as needed for pain 1-5, Percocet as needed for pain greater than 5 or breakthrough pain. Make sure max dose of Tylenol daily was not exceeded. Physician orders documented: - On 6/12/2024, give 2 tablets of acetaminophen 325 milligrams every 4 hours as needed for mild pain. - On 9/18/2024, give 2 tablets of acetaminophen 325 milligrams every 4 hours as needed for pain level between 1 and 5, do not exceed maximum daily dose. - On 9/18/2024, give 1 tablet of Percocet 10-325 milligrams (oxycodone with acetaminophen) every 4 hours as needed for pain level greater than 5, do not exceed the maximum daily dose. The November 2024 Medication Administration Record documented: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- acetaminophen 325 milligrams give 2 tablets by mouth every 4 hours as needed for mild pain with a start date of 8/12/2024 and discontinue date of 11/29/2024. The acetaminophen was not administered in 11/2024. - acetaminophen tablet 325 milligrams, give 2 tablets by mouth every 4 hours as needed for pain rated 1-5 with a start date of 9/18/2024. The medication was administered on 11/7/2024 for a pain level of 5 by Licensed Practical Nurse #13. The November 2024 Medication Administration Record documented Percocet oral tablet 10-325 milligrams, give 1 tablet by mouth every 4 hours as needed for pain rated greater than 5, do not exceed maximum daily dose for acetaminophen. Percocet was not given according to physician ordered parameters (pain level greater than 5) at the following times: - On 11/5/2024 at 9:09 AM by Licensed Practical Nurse #13 for a pain level of 5 and at 3:14 PM by Licensed Practical Nurse #49 for a pain level of 5. - On 11/6/2024 at 1:04 AM by Licensed Practical Nurse #43 for a pain level of 0. - On 11/7/2024 at 4:39 AM by Licensed Practical Nurse #50 for a pain level of 5. - On 11/9/2024 at 8:59 AM by Licensed Practical Nurse #13 for a pain level of 4. - On 11/10/2024 at 4:15 AM by Licensed Practical Nurse #43 for a pain level of 0. - On 11/13/2024 at 7:56 AM by Licensed Practical Nurse #13 for a pain level of 4. - On 11/14/2024 at 12:40 PM by Licensed Practical Nurse #13 for a pain level of 4. - On 11/15/2024 at 1:40 PM by Licensed Practical Nurse #49 for a pain level of 0 and at 9:08 PM by Licensed Practical Nurse #43 for a pain level of 0. - On 11/16/2024 at 8:37 PM by Licensed Practical Nurse #51 for a pain level of 5. - On 11/18/2024 at 9:00 AM by Licensed Practical Nurse #13 for a pain level of 4. - On 11/19/2024 at 8:45 AM by Licensed Practical Nurse #13 for a pain level of 4. - On 11/22/2024 at 8:18 PM by Licensed Practical Nurse #51 for a pain level of 5. - On 11/24/2024 at 5:22 AM by Licensed Practical Nurse #43 for a pain level of 0. - On 11/28/2024 at 12:35 AM by Licensed Practical Nurse #50 for a pain level of 5. - On 11/29/2024 at 9:12 AM by Licensed Practical Nurse #13 for a pain level of 5. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/29/2024 at 11:39 AM, Pharmacist #37 stated they completed a monthly medication review on all residents for the facility. They had sent a recommendation on 9/13/2024 for clarification of a pain scale to indicate whether Tylenol or Percocet was given to Resident #17. After the facility clarified the order, there was a second Tylenol order. The previous Tylenol order should have been discontinued when the new Tylenol order with the pain scale was entered in September. They had monitored if the medications were being appropriately given based on the pain scale and overlooked the second Tylenol order. They had seen duplicate orders in resident's charts and usually caught them during the monthly medication review and put them in the recommendation to be discontinued, but they missed this one in the past 2 monthly medication reviews. With two active orders, the opportunity existed to chart on both orders and give both orders and the resident could receive the Tylenol at an increased frequency or too much Tylenol, but they did not. They had only received one total dose of Tylenol since the second order was entered. Medications should also be reviewed by the physicians during required routine visits. During an interview on 12/2/2024 at 2:33 PM, Licensed Practical Nurse #13 stated if there were two Tylenol orders, they would not know which one to document on. If they saw a second order, they would go to the Unit Manager for clarification. They always gave Resident #17 Percocet, so they did not get too much Tylenol. They gave Tylenol once when the Percocet was not available at the facility. They should not have given the resident Percocet for a pain level of 4 but the resident always requested the Percocet, so they just gave it to them. They stated they should have followed physician orders because the physician knew what was best for the resident. During an interview on 12/2/2024 at 2:46 PM, Licensed Practical Nurse #43 stated if the resident requested the Percocet, they just gave it. It was important physician orders were followed and the right medication was part of the 6 rights to medication administration. While it was important physician orders were followed, it was the resident's right to get the medication they wanted and if they did not give Resident #17 Percocet, they would report them. It was not appropriate they administered Percocet with a pain level of 0 but Resident #17 wanted Percocet every 4 hours and did not want the Tylenol. They should have called the doctor for a one-time order if the pain level did not indicate the Percocet should be given but the resident requested it. During an interview on 12/4/2024 at 9:08 AM, Licensed Practical Nurse Assistant Unit Manager #38 stated they clarified an order for Tylenol for Resident #17 that included a pain scale per the pharmacy recommendation. They thought the electronic system automatically discontinued the old order when a new order was put in. With two active Tylenol orders the resident could have received Tylenol before it was due or too much Tylenol. Tylenol should be administered for pain 1-5 and Percocet should not be given for pain less than 5. If the pain score was 5, it was unclear to them which medication should be given and they would have to clarify the orders. The nurses that gave the Percocet with a pain level less than 5 were not following the physician orders. It was important physician orders were followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/2024 at 9:28 AM, Registered Nurse Unit Manager #14 stated when an order was clarified, the new order took precedence, and the old order was discontinued. If a nurse saw 2 orders for the same medication, they hoped they clarified with the physician. Resident #17's Tylenol order was given for pain 1-5 and Percocet for pain greater than 5. If the pain score was 5 or below, Tylenol should be given. The nurses should have followed physician orders, but they knew Resident #17 requested the Percocet. Even if the resident requested Percocet, orders still needed to be followed so there was no harm to the resident. Review of the Medication Administration Record showed the nurses were not following the physician orders and this was a quality-of-care issue. During an interview on 12/4/2024 at 10:00 AM, the Assistant Director of Nursing stated Licensed Practical Nurse Assistant Unit Manger #38 should have discontinued the old Tylenol order when the new order was placed. Nurses should look at the medication orders prior to giving a medication. Pharmacist #37 usually caught duplicate orders during the monthly medication review. The physicians should review the resident's medications with every visit. The Medication Administration Record documented the nurses were not following physician orders per the pain scale. The orders should be followed even if the resident requested Percocet. Percocet should not be given unless the pain level was 6 or above. During an interview on 12/4/2024 at 12:03 PM, the Medical Director/ Attending Physician stated medications were not always reviewed during physician visits. The pharmacist and the nurses reviewed the medications monthly and should have discontinued an old Tylenol order. Percocet should not be given for a pain score of 5 or less. Orders should be followed and if they were not followed, education needed to be provided. This was the protocol, physicians ordered, and nurses carried out the orders. 10NYCRR 415.12 50561 .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 50561 Based on observations, record review, and interviews during the recertification and abbreviated (NY00322525 and NY00322126) surveys conducted 11/21/2024-12/4/2024, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers for 1 of 1 resident (Resident #30) reviewed. Specifically, Resident #30 experienced a decline in physical mobility and developed an unstageable pressure wound (full thickness tissue loss in which the base of the ulcer is covered with non-viable tissue) and cellulitis to their heel. There was no documented evidence that preventative measures were implemented to prevent skin breakdown when the resident's mobility declined. Additionally, the resident's heels were observed resting directly on the mattress, their mattress was deflated, and the resident was not provided with timely incontinence care. This resulted in actual harm to Resident #30 that was not Immediate Jeopardy. Findings include: The undated facility policy, Pressure Ulcer/Injury, Prevention, documented preventing skin breakdown and development of pressure ulcers/injuries included; assessment guidelines including cognitive impairment, urinary incontinence, weight, mobility status, and refusal or resistance of care. Supplies/equipment included appropriate support surfaces for bed, pillows, and other positioning devices as necessary. Procedures included identifying high risk residents, developing a care plan to eliminate or minimize risk factors, keeping sheets dry, and positioning with appropriate surfaces to protect boney prominences. The undated facility policy, Positioning the Resident, documented the purpose of relieving pressure and preventing skin breakdown. Assessment guidelines included ability of the resident to position self. Supplies/equipment included pillows and heel protectors and care plan documentation guidelines included listing appropriate positioning procedures. The undated facility policy, Incontinence Care, documented the purpose was preventing skin breakdown and keeping skin clean, dry, and free of irritation and odor. Resident #30 had diagnoses including unspecified dementia and diabetes. The 8/21/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject care, required partial/moderate assistance for positioning, transfers, and walking, was always incontinent of bowel and bladder, had a significant weight loss, was at high risk for developing pressure ulcers/injuries, did not have unhealed pressure ulcers, used a pressure reducing device for the bed and chair, and received pressure ulcer care. The Comprehensive Care Plan initiated 4/19/2024 documented: - the resident had an activities of daily living self-care performance deficit related to dementia. There were no interventions documented for incontinence care, transferring, and positioning. - the resident could be resistive to care and would often refuse AM and PM care and assistance with hygiene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- the resident had potential for impairment to skin integrity related to frequent refusals of incontinence care and fragile skin. Interventions included incontinence care to be completed after each episode of incontinence and as needed; keep skin clean and dry; regular foam cushion to chair at all times while out of bed; toilet every two (2) hours and as needed; use draw sheet with positioning; and pull up incontinence briefs in bed. The 8/6/2024 at 6:21 AM Director of Nursing progress note documented staff reported a decline in the resident's ambulation status and required the use of a wheelchair and had a decrease in food and fluid intake. There was no documented evidence the attending physician was notified of the resident's change in condition. The 8/21/2024 at 10:50 AM Minimum Data Set Registered Nurse #20 progress note documented the resident was scheduled for a significant change Minimum Data Set assessment due to a decline in ambulation and eating and a significant weight loss. A recovery within two weeks was unlikely. The 8/21/2024 Director of Rehabilitation Physical Therapy Evaluation and Plan of Treatment documented a referral was ordered due to functional decline and significant change. The resident required total assistance for bed mobility and transfers. The resident's prior level of functioning was supervision for transfers, bed mobility, and ambulation. The 9/17/2024 at 2:36PM Registered Nurse/Certified Wound Nurse #21 progress note documented they were called to assess a new skin finding. During assessment they found a hard, dark scab with lifting edges on the left heel. There was greenish, tannish purulent (puss) drainage coming out from around the scab. There were no documented measurements. The Comprehensive Care Plan initiated 9/17/2024 documented the resident had a left heel unstageable pressure ulcer. Interventions included monitor nutritional status, monitor ulcer for signs of progression or decline, notify provider if no signs of improvement on current wound regime, provide skin care per facility guidelines and as needed, and provide wound care per treatment order. The 9/17/2024 physician order documented the resident was to receive Clindamycin 300mg (an antibiotic) four times a day for 7 days for a left heel infection. The 9/18/2024 Medical Director comprehensive review documented the resident was recently started on Clindamycin for cellulitis of the left heel and resident had left heel erythema (redness of skin) consistent with cellulitis. The 9/19/2024 weekly skin sheet completed by Licensed Practical Nurse #13 documented the resident's skin was intact and there were no new concerns. The 9/27/2024 Minimum Data Set assessment documented the resident required substantial/maximal assistance with transfers and walking 10 feet, had 1 unstageable pressure ulcer not present on admission, used a pressure reducing device for the bed and chair, received pressure ulcer care, application of dressings to feet, and received an antibiotic. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 10/4/2024 unsigned wound evaluation documented the left heel wound measured 2.28 centimeters x 1. 86 centimeters, was unstageable, in house acquired and was improving. The 10/28/2024 Physical Therapy Discharge Summary completed by the Rehabilitation Director documented a recommendation for assistance of 2 for all mobility. The resident had reached maximum potential with skilled services. The 11/21/2024 physician order documented calcium alginate (an absorbent wound care product) to the left heel wound, cover with a super absorbent dressing once a day on the evening shift. The Comprehensive Care Plan for the presence of an unstageable pressure ulcer on the left heel was revised 11/26/2024 to include an air overlay (mattress) to the bed. There was no documented evidence of interventions to alleviate pressure to the left heel. The following observations were made of Resident #30 lying in bed with both heels resting directly on the mattress: - on 11/26/2024 at 8:34 AM - on 11/26/2024 at 2:48 PM - on 11/27/2024 at 9:01 AM - on 12/3/2024 at 8:26 AM and 11:13 AM During an observation on 12/3/2024 at 8:26 AM, the resident was lying in bed on a tan overlay air mattress. The mattress pump was not turned on and the mattress was completely deflated. The resident's heels were resting directly on the deflated mattress. During an observation on 12/3/2024 at 11:15 AM, the resident was lying in bed. Certified Nurse Aide #34 entered the room and removed the top linens to perform care. The resident had an incontinence brief on and was lying on an incontinence pad. The brief and the incontinence pad were soaked through, and the bottom sheet had a large, dried, brown ring extending from the resident's lower back to their upper thighs and beyond both hips. The resident's nonslip socks were removed, there was no dressing on the left heel. The dressing was not found in the bed or in the nonslip sock that was removed. The December 2024 Treatment Administration Report documented the left heel dressing was applied on the evening of 12/2/24 by Licensed Practical Nurse #35. During an interview on 11/26/2024 at 2:49 PM, Certified Nurse Aide #6 stated they would know if a resident was supposed to have a wound dressing because they would see it and just knew. Any specific skin interventions would be on the resident care card. They tried to turn and position residents throughout the shift, and those with heel wounds should have their heels offloaded. Resident #30 fidgeted a lot and used to have booties (pressure relief) but kicked them off, but they could not remember how long ago that was. Offloading heels and turning residents was important to prevent skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/26/2024 at 3:43 PM, Registered Nurse/Certified Wound Nurse #21 stated preventative measures such as specialized mattresses, heel elevation, heel boots, skin prep, cushions, and repositioning schedules could be started by anyone any time there was a need. They considered poor appetite, weight loss, history of wounds, diabetes, failure to thrive, and decline in mobility risk all factors in the development of skin breakdown. Resident #30 had a recent decline and was not getting out of bed or eating much and was quite sick after having COVID-19. Their left heel wound was initially a deep tissue injury. They thought the current intervention was a basic air mattress overlay that was initiated once the heel wound was discovered but was not listed on the resident's care plan. They thought the resident had refused pillows and boots in the past and expected that would be documented. They stated even if there was a history of refusing it should still be attempted. Offloading heels was important because lack of blood flow could cause injury to the resident that could lead to infection. During an interview on 12/3/2024 at 11:36, Certified Nurse Aide #34 stated their shift started at 6:00 AM and they were responsible for providing Resident #30 with incontinence and repositioning care every 2 hours. They had not changed the resident since the start of their shift and reported to Licensed Practical Nurse #35 that the resident refused when they attempted to do so at 7:30 AM. They were unaware the resident should have a dressing on their left heel. The resident should be repositioned, and incontinence care provided every couple of hours and if not, they could get a bladder or wound infection. During an interview on 12/3/2024 at 11:54 AM, Licensed Practical Nurse #35 stated toileting and repositioning care should be provided every two (2) hours and if a resident refused, they expected to be notified so they could intervene. Resident #30 had on going skin issues and no one reported to them they had refused care. During a follow-up interview on 12/3/2024 at 1:02 PM, Licensed Practical Nurse #35 stated there was not a process in place to check wound dressings in between dressing changes. Resident #30 had a dressing to their left heel that came off frequently and if it was found off, it should be replaced. The certified nurse aide should report if a dressing was missing. Intact dressings were important to prevent infection of the wound. During a follow-up interview on 12/3/2024 at 12:17 PM and 1:16 PM, Registered Nurse #21 stated overlay air mattresses should be on all the time when the resident was in bed, otherwise there was no benefit to the resident. There was not a process to check for wound dressing integrity and if a certified nurse aide knew there was supposed to be a dressing, they should report it missing. Resident #30 had an air mattress overlay that should always be on, and they should be repositioned and provided incontinence care at least every two (2) hours. They were unaware there was a problem with the resident's dressing staying on, as no one had ever reported that to them. The resident's wound order included application of calcium alginate which absorbed drainage, debrided (removed dead tissue), and protected the wound. If the dressing was not in place, it could increase the chance of infection and lengthen the healing time. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/26/2024 at 2:56 PM, Licensed Practical Nurse #33 stated the facility used interventions such as booties, repositioning, special mattresses, and skin prep to prevent residents from developing wounds. Residents who were thin, contracted, or had impaired mobility were prone to skin breakdown and a resident with a heel wound should have pressure offloaded. Resident #30 was once very mobile but had declined the past few months and no longer walked at all. After reviewing the resident's care plan, they stated there were no specific interventions in place. Pillows under the heels was basic nursing care and if a resident were to refuse boots, skin prep and pillows could be used as most everyone tolerated those. No one had reported to them the resident refused to have their heels up and if that were happening it should be documented. Offloading heels was important to prevent worsening of the wound. During an interview on 12/3/2024 at 8:34 AM, Certified Nurse Aide #10 stated the facility used air mattresses. They made sure the pump was on and mattress was inflated. If not, they would trouble shoot and if still not working, they would report it. They did not think Resident #30 had an air mattress, but after entering the resident's room they saw they did have one, but it was not turned on. During an interview on 12/3/2024 at 8:43 AM, Licensed Practical Nurse #13 stated the facility used air mattresses and they should be listed in the care plans if in use. Their responsibility was to make sure it was plugged in and turned on. They assumed the aides would let them know if it was not inflated. Air mattresses were used to help bed sores and should be on at all times. They thought Resident #30 had an air mattress but did not know why they had one other than having a lot of redness to their bottom. During an interview on 12/3/2024 at 1:55 PM, the Director of Nursing stated preventative skin measures such as heels up, heel boots, and specialized mattresses should be put in place if a resident had a decline. They expected residents to be changed every couple of hours particularly those residents that already had skin breakdown. Air mattresses should be checked at least once a shift to ensure they were on. Certified nurse aides should report if a wound dressing had come off. Currently there was not a process to check wound dressing placement and if the aide did not know there was supposed to be a dressing it was possible it could go undressed until the next time it was due to be changed. Resident #30 had an in house acquired unstageable pressure ulcer to their left heel that had been treated for cellulitis. The resident had a decline, was not eating or drinking, acquired COVID-19, and their mobility declined to the point they were no longer walking. An air mattress was put on their bed, but they were not sure when and were not aware of any other specific interventions that were put in place to prevent skin breakdown. The resident should not be on an air mattress that was not inflated as deflated mattresses did not offload pressure. During an interview on 12/4/2024 at 12:08 PM, the Medical Director stated if a resident was prone for skin breakdown the resident should be repositioned, use special mattresses, pillows, and foams to offload areas. If those measures were not in place, a resident could develop a pressure sore or have skin breakdown. They were unfamiliar with Resident #30 and did not have access to their record to review further. 10 NYCRR 415.12(c)(2)

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	335658	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groton Community Health Care Ctr Res Care Fac	120 Sykes Street Groton, NY 13073

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48895 Based on observations, record review, and interviews during the abbreviated survey (NY00359606) conducted 11/7/2024, and the recertification and extended surveys conducted 11/21/2024-12/4/2024, the facility did not ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, administration failed to ensure that residents received appropriate quality of care by allowing the following deficient practices to exist, placing residents at risk for serious injury, serious harm, serious impairment, or death, F 689 Accident Hazards and F 700 Bedrails; failed to ensure policies and procedures were properly identified, communicated, and consistently implemented; was not aware of the extent of the deficient practices cited; and did not report equipment failure when the facility did not have hot water for 10 days. Additionally, administration did not provide surveyors with requested and required documents (form CMS-802, Matrix for Providers; staffing schedules; beneficiary notices; key personnel information; and facility assessment) in a timely manner, which impeded the survey process. Findings include: The facility job description, Job Title: Administrator, dated 12/16, documented the Administrator was responsible for being the point person for any inquiries, maintenance concerns, etc. The duties and responsibilities included: being Responsible for overseeing the day-to-day operations of the skilled nursing facility and ensuring compliance with all regulatory agencies governing healthcare delivery and rules of certifying bodies by continually monitoring operations, programs, and the physical plant. They were to keep up to date on changes in the regulatory environment and provide direction to facility staff. The facility policy, Quality Assurance and Performance Improvement Program, dated 12/2023, documented the objective of the Quality Assurance and Performance Improvement Program was to provide a means to measure current and potential indicators for outcomes of care and quality of life. The administrator was responsible for assuring that this facility's Quality Assurance and Performance Improvement program complied with Federal, State, and local regulatory agency requirements. The Quality Assurance and Performance Improvement committee reported directly to the administrator. The Quality Assurance and Performance Improvement plan described the process for identifying and correcting quality deficiencies. Key components of this process included tracking and measuring performance; establishing goals and thresholds for performance measurement; identifying and prioritizing quality deficiencies; systematically analyzing underlying causes of systemic quality deficiencies; developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. Deficient Practice Information: Resident's Free from Accident, Refer to the citation text under F689. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility failed to ensure the residents' environment remained free of accident hazards for 2 of 2 resident units (First and Second Floors). Specifically, hot water temperatures in resident sinks and common shower rooms on the First and Second Floors exceeded temperatures of the 110 degrees Fahrenheit standard. This resulted in no actual harm with likelihood of serious harm, serious injury, serious impairment, or death that is Immediate Jeopardy and Substandard Quality of Care for all 70 residents residing in the facility. Bed Rail, Refer to the citation text under F700. The facility failed to ensure correct installation, use, and maintenance of bed rails to ensure there was no gap between the bed rail and mattress wide enough to entrap a resident's head or body for 5 of 5 residents (Residents #2, #14, #29, #33, and #46) reviewed. Specifically, Residents #2, #14, #29, #33, #46 did not have routine inspections of their mattress and bed rails for areas of possible entrapment. Additionally, the facility failed to evaluate alternatives to bed rails, failed to review the risks and benefits of bed rails with the resident or resident representative, and failed to obtain informed consent prior to the installation of bed rails. This resulted in no actual harm with likelihood of serious harm, serious injury, serious impairment, or death that is Immediate Jeopardy for all 32 residents with bed rails. Safe, Clean, Comfortable Environment, Refer to the citation text under F584. The facility did not ensure residents had a safe, clean, comfortable, and homelike environment for 2 of 2 nursing units. Specifically, there was no hot water in the facility from 10/29/2024-11/8/2024. During an interview on 11/7/2024 at 3:16 PM, the Administrator stated the families were not notified when the facility was without hot water. The Administrator stated that being without water would require notification, but the facility had interventions to substitute for the lack of hot water in many cases. The facility was without hot water for 10 days. They did not notify the Department of Health, as they thought the lack of hot water would be fixed in a shorter time. They stated they thought they had their bases covered with the interim measures they had in place. During an interview on 11/22/2024 at 5:55 PM, the Administrator stated if the facility was not using the bed measuring tool, they did not know where it was. They purchased a tool when they started at the facility in October of 2020. During an interview on 11/29/2024 at 12:22 PM, the Administrator stated that the previous Administrator had approval from the Board of Directors to buy 20 beds in 2019 or 2020. When the Board of Directors approved the spending, the previous Administrator got 50 of the cheaper beds at the same price as the 20 beds that were originally approved for. The cheaper beds were the beds currently being used in the facility. They stated the beds were meant for home use, not for institutional use. The bed manual outlined the use of half or full rails, which they would not use in their facility. The bedrails used on the beds were purchased as over market devices, not specific to any type of bed. During an interview on 12/4/2024 at 11:39 AM, the Administrator stated there were no current audits for bedrails or water temperatures. Additionally, they stated there were no current audits for hand hygiene, call bell times, activities of daily living, nursing education and competencies, pressure wound prevention, or care plans. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Survey Required Documents: The recertification survey team entered the facility on 11/21/2024 at 9:30 AM. During the entrance conference interview on 11/21/2024 at 9:41 AM, the Administrator was provided a hardcopy of the entrance conference documents required for survey and included items that needed to be submitted electronically. Items were grouped together by the time frames they were required. Information required from the facility immediately upon entrance included the complete matrix for new admissions; within one hour of entrance schedules for all staff, separated by department, for the survey time period and a list of key personnel with their location and phone number; within four hours of entrance the Facility Assessment; and within 24 hours of entrance beneficiary notices. The following required recertification survey documents were received: - The facility mealtimes were received on 11/21/2024 at 3:12 PM (over 4 hours late). - The food menus were received on 11/22/2024 at 10:35 AM for the regular menus (over 23 hours late) and 10:39 AM for the therapeutic menus (over 23 hours late). - The infection prevention control program was received on 11/22/2024 at 12:25 PM (over 22 hours late). - The Beneficiary Notice List was received on 11/27/2024 at 5:44 AM (over 4 days late). - The Facility Assessment was received on 11/27/2024 at 8:17 AM (over 5 days late). - The Key Personnel List was received on 11/27/2024 at 8:17 AM (over 5 days late). - The Quality Assurance and Performance Improvement committee information was received on 11/29/2024 at 1:15 PM (over 7 days late). - The Nursing Staff schedule was received on 12/2/2024 at 1:54 PM (over 11 days late). - The Environmental Services schedule was received on 12/2/2024 at 2:28 PM (over 11 days late). - The Nutrition and Food Service schedule was received on 12/2/2024 at 3:42 PM (over 11 days late). On 11/21/2024 at 10:12 AM, an electronic copy of the entrance conference documents for survey was sent to the Administrator outlining all the required documents and items discussed during the Entrance Conference interview. On 11/21/2024 at 1:18 PM, the form CMS-802, Matrix for Providers was requested from the Administrator a second time, as the document provided was a website that could not be opened. Additionally, an electronic mail was sent stating there were several documents missing based on the time frame needed. These included mealtimes, menus, medication administration times, key personnel list, and infection prevent information. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/22/2024 at 8:39 AM, an electronic mail was sent to the Administrator stating the following items were still missing or incomplete: - Information Needed from the Facility with one hour of Entrance included menus; medication storage information; schedules for all staff, separated by department, for survey time period; and key personnel list. - - Information needed from the facility within four hours of entrance included infection prevention and control information; Quality Assurance and Performance Improvement plan and committee information; and the Facility Assessment. On 11/26/2024 at 10:43 AM, an electronic mail was sent to the Administrator stating the following items were still missing or incomplete: - Information needed from the facility with one hour of entrance included schedules for all staff, separated by department, for survey time period; and key personnel list. - Information needed from the facility within four hours of entrance included Quality Assurance and Performance Improvement committee information; and the Facility Assessment. - Information needed from the facility within 24 hours of entrance included the beneficiary notice list, as the one sent was blank. On 11/29/2024 at 12:04 PM, an electronic mail was sent to the Administrator stating the following items were still missing or incomplete: - Information needed from the facility with one hour of entrance included schedules for all staff, separated by department, for survey time period. - Information needed from the facility within four hours of entrance included Quality Assurance and Performance Improvement committee information. During an interview on 11/29/2024 at 12:22 PM, the Administrator was reminded about missing Entrance Conference documents during. During an interview with the Administrator on 12/2/2024 at 11:19 AM, the Entrance Conference staffing schedules were requested again. The Administrator stated that staff's timecards were sent. It was explained that the Department of Health surveyors were looking for schedules related to who was in the building and when, not how many hours were worked by the staff. During an interview on 12/2/2024 at 11:20 AM, the Nursing Staff Coordinator #54 stated they had the schedule for the nursing staff for the month and they would scan the documents for the Administrator to send. During a follow-up interview on 12/2/2024 at 1:11 PM, the Nursing Staff Coordinator #54 stated they sent the nursing schedules to the Administrator via electronic mail on 12/2/2024 at 11:21 AM. During an interview on 12/2/2024 at 1:37 PM, the Entrance Conference staffing schedules were requested from the Administrator again. (continued on next page)

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