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
	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	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)

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 49448 Based on interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure a private space for monthly Resident Council Meetings. Specifically, 5 of 5 anonymous residents present at the resident group meeting stated the facility arranged monthly Resident Council meetings in the first floor dining room where uninvited staff were also present. Findings include: The facility policy, Resident Rights, documented all residents had the right to self-determination, confidentiality, and to communicate in person with privacy. The facility policy, Resident Council, dated 2/2021, documented staff, visitors, and other guests may attend resident council meetings if they were invited by the respective resident group. The resident council group was provided with space, privacy, and support to conduct meetings. During a resident group interview on 11/21/2024 at 1:59 PM, 5 of 5 residents stated the monthly Resident Council meetings were not held in a private space. The meetings were held in the first floor dining room and staff, usually the Director of Social Work and the Director of Activities, were always present because the residents were told they had to be supervised. The Director of Social Work and the Director of Activities were not invited to attend the meeting by the members. The Resident Council members were not aware they could request a private space for meetings without staff present. During an interview on 12/3/2024 at 10:11 AM, the Director of Activities stated the Resident Council meetings were always the third Thursday of the month and were held in the first floor dining room. The residents were not allowed to be in the dining room unattended, so they had to attend the Resident Council meetings. They had to miss care conference meetings on the resident council meeting days because they had to be present for the resident council meeting. During an interview on 12/3/2024 at 1:28 PM, the Director of Social Work stated they attended the Resident Council meetings as a second person and the meetings were run by the Director of Activities. Staff needed to be present for resident supervision during Resident Council meetings therefore the meetings could not be held without staff present. 10NYCRR 415.5(c)(1-5)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on record review and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 3 of 3 residents (Residents #28, #38, and #223) reviewed. Specifically, Residents #28 and #38 remained in the facility after discontinuation of Medicare Part A services with benefits remaining and the facility did not provide timely Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) as required; and Resident #223 was discharged from the facility and was not provided timely Notice of Medicare Non-Coverage (Centers for Medicare and Medicaid Services-10123) as required. Findings include: The Center for Medicare and Medicaid Services form instructions for the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055, expiration date 1/31/2026, documented a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (form 10055) must be issued by providers to beneficiaries in situations where Medicare payment was expected to be denied. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage must be delivered far enough in advance that the beneficiary or representative had time to consider the options and make an informed choice prior to services ending. The 9/19/2024 facility document, [Skilled Nursing Facility] Beneficiary Notices New [Skilled Nursing Facility Advanced Beneficiary Notice] [October] 2024, documented effective delivery of the notice occurred when the beneficiary had both received the notice and comprehended its contents. The notice was issued no later than two days before termination of services. Telephone contact was confirmed by written notice, mailed on that same day via certified mail, and return receipt requested. When notices were returned by the post office, proof of the date mailed was retained. 1) Resident #28 had diagnosis including epilepsy (seizure disorder) and dementia. The 7/24/2024 Minimum Data Set assessment documented the resident had intact cognition, it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment and the resident had a Medicare-covered stay with a start date of 5/20/2024 and an end date of 7/24/2024. The resident remained in the facility. The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #28's effective end date of services was 7/24/2024. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 letter did not have options selected regarding the discussion with the representative. There was a hand printed note on both documents that the resident's representative provided verbal acknowledgement on 7/23/2024 one day before the end of services. There was no documented evidence the telephone contact with resident's representative was confirmed by written notice mailed on the same date. (continued on next page)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 9:14 AM, Resident #28's representative stated therapy had discussed the progress Resident #28 made. They stated they did not recall being provided anything in writing regarding Resident #28's services but recalled a verbal conversation. They stated the facility had great verbal communication, but paperwork was a short fall. 2) Resident #38 had diagnosis including dementia and spinal stenosis. The 10/25/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, it was a Skilled Nursing Facility Part A Prospective Payment System (a method of reimbursement used by Medicare that pays a predetermined amount for a service) discharge assessment and the resident had a Medicare-covered stay with a start date of 10/7/2024 and an end date of 10/25/2024. The resident remained in the facility. The Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 letter documented Resident #38's effective end date of services was 10/25/2024. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage Center for Medicare and Medicaid Services-10055 letter did not have options selected regarding the discussion with the representative. There was a hand printed note on both documents that the resident's representative provided verbal acknowledgement on 10/23/2024. There was no documented evidence the telephone contact with resident's representative was confirmed by written notice mailed on the same date. During an interview on 12/3/2024 at 8:45 AM, Resident #38's representative stated that they were not provided information regarding skilled nursing coverage for Resident #38. If they had been given the information, they would have appealed the decision, but they had been working to get coverage for Resident #38. They were made aware they could have appealed the decision after the time frame had passed. 3) Resident #223 had diagnosis including right knee effusion and encounter for orthopedic aftercare. The 8/19/2024 Minimum Data Set assessment documented the resident had intact cognition, it was a Nursing Home Discharge and return was not anticipated, and the resident had a Medicare-covered stay with a start date of 8/5/2024 and an end date of 8/19/2024. The 8/15/2024 at 2:30 PM discharge summary completed by Licensed Practical Nurse Unit Manager #16 documented Resident #223 was discharged home from the facility on 8/19/2024. The 8/16/2024 at 12:39 PM progress note completed by the Director of Social Work #24 documented that they met with Resident #223 and reminded them of their discharge plans, and the resident needed to hang in there a couple more days because they were being discharged on [DATE]. There was no documented evidence the Notice of Medicare Non-Coverage for Centers for Medicare and Medicaid Services-10123 was provided to the resident. (continued on next page)

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 11:56 AM, the Director of Social Work #24 stated they were responsible to ensure the delivery of the beneficiary notice letters to the resident or the resident's representative was completed. They stated they did not have receipt of a certified letter for Resident #28, they just held on to the letters until the representative visited again. The Director of Social Work stated Resident #38's representative was not mailed a letter, but the letter was left on the nightstand in the resident's room for the representative. They did not have a note documenting whether they received the letter or not. They stated if they had to send something certified they would give it to Administrative Assistant #28 for them to send, or they would stop by the U.S. Post Office on their way home. They stated they only sent beneficiary notices via certified mail if the family was out of state, and they knew they would not be in to see the resident. Even when they sent items certified they did not keep the receipt, as they did not know they had to. The Director of Social Work stated Resident #223 was a resident-initiated discharge. They were told that any resident-initiated discharge did not need beneficiary notification regardless of the length of stay remaining. They stated if a resident requested to go home, they did not have to do anything because the resident asked to leave. Resident #223 was a planned discharge. They met as a team to ensure the resident services were in place and they picked a day that was agreeable with the resident for discharge. Resident #223 spoke with staff with interest to discharge home on 8/15/2024, and the resident did not discharge out of the facility until 8/19/2024, the last covered day of services. The Director of Social Work stated it was important for resident or representative to get the beneficiary notices, so they knew they were getting cut from services and were aware of the appeal process. They stated they did not receive any formal training on how to do beneficiary notices. 10 NYCRR 483.10(g)(18)

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 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)

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 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)

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 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)

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 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)

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 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49448 Based on observations, record review, and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure a process was in place for residents to have their grievances addressed appropriately for 70 of 70 residents residing in the facility. Specifically, information on how to file a grievance and grievance forms were not available to the residents and an official grievance officer was not identified. Additionally, 5 of 5 anonymous residents present at the resident group meeting stated they did not know who the grievance officer was or how to file a grievance. Findings include: The undated facility document, Resident Grievance/ Complaint Procedures, documented the resident grievance complaint form was obtained from the nurse's station or the business office. Residents signed the form or filed anonymously. The completed form was given to the Administrator or their designee. If the Administrator was not available, the form was given to the supervisor on duty, or it could be submitted anonymously to the person the resident wished to handle the grievance or complaint. The undated facility policy, Grievances/ Complaints, Filing, documented residents, family, and resident representatives had the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal. A copy of the grievance/ complaint procedure was posted on the resident bulletin board. The results of the grievances were maintained on file for a minimum of three years from the issuance of the grievance decision. (The policy provided a phone number and email address for former Director of Social Work #36 that no longer worked at the facility.) The facility document and policy did not include a means to submit a grievance anonymously or name the current designated grievance officer. The grievance log for grievances filed after the last standard survey on 2/24/2023 was requested. The log documented 3 grievances in total for the facility since 2/24/2023. One was from 9/8/2024 and two were from 12/4/2024, the day the log was received. There was no documented evidence of a grievance log for the year 2023. On 11/21/2024 at 1:59 PM during a resident group meeting, 5 of 5 anonymous residents stated they did not know how to file a grievance or who the official grievance officer was. During an observation on 11/25/2024 at 8:38 AM, the grievance policy and the grievance forms were on the First Floor, each in a plastic sleeve, at the upper right top of the bulletin board, just below the ceiling, behind a locked door to the unit. The documents were not posted prominently. During an observation on 12/3/2024 at 11:29 AM, the grievance policy and the grievance forms were observed on the Second Floor, each in a plastic sleeve, at the bottom left corner of the bulletin board behind a locked door to the unit. The documents were not posted prominently. (continued on next page)

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 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 12/3/2024 at 10:11 AM, the Director of Activities stated they followed up on concerns voiced during resident council meetings and used a resident response form. The Director of Social Work handled any grievances outside of concerns voiced during resident council meetings. During an interview on 12/3/2024 at 1:28 PM, the Director of Social Work stated they had grievance forms and they asked families who voiced more than a mild complaint, to complete the form. They expected staff to inform them if a resident had a complaint, as the residents did not come to them because they could not get through the locked door. If staff verbalized a resident complaint, they had a formal grievance form they completed. They did not have the title of Grievance Officer at this facility. There was nowhere to turn in a written grievance anonymously, it had to be turned into a staff member who would then get it to them. During an interview on 12/4/2024 at 11:39 AM, The Administrator stated it was important to have an official grievance officer, so someone was responsible and had a primary focus on the issues ranging from complaints of cold toast to the care of the residents. The Director of Social Work was the official grievance officer. 10NYCRR 415.3(C)(1)(ii)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50561 Based on observations, record review, and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure the development and implementation of a comprehensive person-centered care plan for 1 of 1 resident (Resident #31) reviewed. Specifically, Resident #31 did not have an individualized person-centered care plan that addressed dementia with behavioral symptoms or use of psychotropic medications (medications used to treat mood disorders). Findings include: The facility policy, Psychotropic Medication Policy and Procedure, dated 3/2017, documented the facility ensured appropriate use, evaluation and monitoring of psychotropic medication use; nursing monitored psychotropic drug use daily noting any adverse effects such as increased somnolence (sleepiness) or functional decline; and the facility's goal was to determine the underlying cause of behavioral symptoms so appropriate treatment of environmental, medical, and/or behavioral interventions could be utilized and met the needs of the individual resident. The facility policy, Behavioral Health Services, dated 5/2017, documented sufficient support was provided to residents that needed Behavioral Health Services and support may include implementation of non-pharmacological interventions as appropriate. The facility policy, Resident Care Planning dated 3/2020, documented designated staff of all disciplines were responsible for the evaluation of the Interdisciplinary Resident Care Plan; the registered nurse reviewed and revised the care plan as appropriate; the resident's problem/needs were discussed by all disciplines; interdisciplinary approaches and specific measurable goals for care were determined or refined by the appropriate discipline; and each discipline entered changes in the care plan problems/needs, approaches, goals and outcomes when the condition of the resident changed. Resident #31 had diagnoses including dementia, anxiety, depression, and unspecified mood disorder. The 11/20/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, mood symptoms nearly every day, required maximum assistance for most activities of daily living, preferred listening to music, reading books magazines or newspapers, spending time outdoors, and doing things with groups of people, and received antidepressant, antianxiety, and antipsychotic medications daily. Psychotropic drug use was triggered as a Care Area Assessment and a care plan was necessary. There was no documented evidence of a Comprehensive Care Plan that included the use of psychotropic drug use including antidepressants, antianxiety, or antipsychotic medications or resident centered interventions that managed behaviors. Physician orders documented the following: - on 7/1/2024 Seroquel 25 milligrams (an antipsychotic) once daily at bedtime for mood disorder. - on 7/23/2024 citalopram (an antidepressant) 10 milligrams once daily for depression. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 8/13/2024 Ativan (an antianxiety) 0.5 milligrams three times a day for anxiety. - on 8/15/2024 Ativan increased to 1 milligram three times a day for anxiety. - on 8/19/2024 Seroquel 25 milligrams increased to three times a day. - on 8/19/2024 Ativan reduced to 0.5 milligrams three times a day for anxiety. - on 8/19/2024 citalopram increased to 20 milligrams once daily for depression. - on 9/11/2024 Rexulti 0.5 milligrams (an antipsychotic) once daily; increased to 1 milligram daily on 9/20/2024; and increased to 2 milligrams daily on 9/27/2024 for unspecified mood disorder. The Medical Director/Attending Physician's Comprehensive Reviews documented: - on 9/9/2024 the resident had been more agitated and irritable and was constantly yelling out. - on 9/12/2024 the resident was more irritable and was yelling out all the time. - on 11/27/2024 the resident appeared more irritable and had increased agitation. Psychologist #52 progress notes documented: - on 9/10/2024 at 12:42 PM the resident continued to almost constantly yell out. - on 10/29/2024 at 1:05 PM the resident continued to have episodes of yelling, being difficult to redirect, uncooperative and agitated. - on 11/25/2024 at 3:00 PM the resident continued to have behaviors, especially yelling out. November 2024 nursing progress notes documented Resident #31 had observed behaviors on 11/6/2024, 11/8/2024, 11/10/2024, 11/14/2024, 11/16/2024, 11/17/2024, 11/19/2024, 11/21/2024, 11/24/2024, 11/26/2024, and 11/28/2024-11/30/2024. Resident #31 was observed: - on 11/21/2024 at 2:13 PM lying in bed and repeatedly making a [NAME] hoo sound followed by a grunting noise. - on 11/26/2024 at 9:00 AM sitting in front of the television in the common area repeatedly moaning and yelling out loudly indiscernible words that drowned out the sound from the television. Other residents were hushing the resident saying, No, don't do that. - on 12/2/2024 at 9:34 AM in their room sitting in a chair hollering indiscernible words repeatedly. - on 12/2/2024 at 1:14 PM lying in their bed moaning loudly. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 12/3/2024 at 8:33 AM, sitting in their chair across from the nurses' station with their eyes closed, moaning. The resident's care instructions active as of 12/3/2024 documented behavior monitoring and interventions. There were no documented resident centered non-pharmacological interventions for behavioral symptoms. During an interview on 12/2/2024 at 1:13 PM, Certified Nurse Aide #42 stated if a resident had behaviors, they tried toileting and repositioning the resident. The resident care cards (care instructions) did not provide much information on behaviors or any specific interventions to try. Resident #31 was declining and yelled out a lot, more now than in the past two weeks. There were not any specific interventions for the resident's behaviors. They thought the resident liked stuffed animals and had a favorite television show but could not remember what one. During an interview on 12/2/2024 at 1:36 PM, Licensed Practical Nurse #35 stated there was information on the care plans regarding behaviors and different ways to calm and redirect a resident. Any new or worsening behavior could be a clue that something was just not normal. Resident #31 appeared broken when they first arrived, was very upset, cried, and had been on a constant decline. They once could say they wanted a drink, to go home, or to go to bed but their communication had declined since admission. Their overall behaviors had worsened. They were spitting out food, yelling and crying and it was difficult to not know what was causing their behaviors. They had reported the physical decline and behaviors to the supervisors and managers many times. During an interview on 12/2/2024 at 1:59 PM, Licensed Practical Nurse Assistant Unit Manager #38 stated they reviewed the care plan in preparation for care conference and any needed changes or updates would be brought to the Nurse Manager or the Director of Nursing to make. Behavior care plans were generated if there was a specific, recurring behavior and included such things as medications and interventions to try before medicating. High risk medications such as psychotropics should be care planned and include symptoms to report so staff knew how to take care of the resident in case there were a problem. Resident #31 had dementia and a lot of anxiety that was not well controlled. They yelled out and did not really know what they were yelling about. The resident received an antipsychotic, an antianxiety and an antidepressant. They did not have a behavioral or psychotropic medication care plan, or anything specifically tailored to them to manage their behaviors. They should be a care plan, so staff knew how to approach and manage the resident's care. The care plan should include resident preferences as they did not want to give unnecessary medications that could cause a decrease in quality of life. During an interview on 12/2/2024 at 2:45 PM, Registered Nurse Unit Nurse Manager #14 stated care plans should include behaviors, dementia, and high-risk medications such psychotropics. A behavior care plan should have simple diversional interventions as well as resident specific preferences. An individualized care plan was important, so everyone knew how to take care of and approach that resident and to minimize having to medicate the resident. Care plans for high-risk medications were important so everyone knew what needed to be monitored. Resident #31 had dementia, took psychotropic medications, and consistently yelled out. Lately, nothing calmed the resident down. Their medications had been adjusted less than a week ago. They did not have a behavior, dementia, or psychotropic medication care plan but should have because those were significant issues for the resident. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 1:40PM, the Director of Nursing stated registered nurses generated and updated the care plans and included behaviors and psychotropic medication use. Behavior care plans should include resident specific interventions to curb behaviors which was important for the resident's well-being and psychosocial health. Psychotropic medication care plans included such things as monitoring for changes in activities of daily living status and mood. Resident #31 had dementia and anxiety and was followed by psychology for their behaviors. They hollered out and their medications were adjusted. There was nothing specifically listed in Resident #31's care plan for behavioral interventions or any documentation that nonpharmacological interventions had been tried. The resident was taking psychotropic medications and was not care planned for them. If the resident was not provided with person centered interventions, they could become more depressed, more anxious, and even delirious. 10NYCRR 415.11(c)(1)

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448 Based on observations, record review, and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 1 resident (Resident #35) reviewed. Specifically, Resident #35 was not provided meaningful activities that met their interests and preferences. Additionally, Resident #35's room was not personalized with preferred activity items, such as a television or radio. Findings include: The facility policy, General Activity Department Guidelines, effective 2/21/2023, documented the facility provided, based on the comprehensive assessment, care plan, and preferences of each resident, an ongoing program to support residents in their choices of activities. The program of activities met the individual needs of each resident and fulfilled basic psychological, social, and spiritual needs. The activities department was ongoing 7 days a week and included weekends. Quarterly reviews were completed and documented in a progress note. Resident #35 had diagnoses including unspecified dementia. The 2/13/2024 Minimum Data Set assessment (a health status tool) documented the resident had moderately impaired cognition, it was somewhat important to have books, newspapers, and magazines to read, do things with groups of people, and do their favorite activities, it was very important to listen to music, be around animals such as pets, keep up with news, go outside for fresh air when the weather was good, and participate in religious services. The Comprehensive Care Plan initiated 2/12/2024 and revised on 11/27/2024 documented the resident had little or no activity involvement related to disinterest, wishing not to participate, and being highly therapy oriented. The resident preferred to spend time in their room watching news programs and soap operas. Interventions included the importance of social interaction and leisure activity time was explained, participation was encouraged, the resident was invited and encouraged to attend, and the resident was reminded they may leave activities at any time and were not required to stay for the entire activity. The 2/12/2024 admission evaluation by the Director of Activities documented the resident's preferred social setting was 1:1 and self-directed. Music, animals, prayer, and family brought the resident comfort. They preferred to spend their free time doing puzzle books, exercises, and watching TV. Interests/ hobbies included cards, games, exercise, sports, gardening, the outdoors, and puzzles. There was no documented evidence of any on-going activities evaluations. The November 2024 Activities Log documented Resident #35 participated in a manicure on 11/4/2024, watched a movie in the common area on 11/5/2024 and 11/6/2024, and was provided with the daily chronicle reading material on 11/6/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the resident was invited to or participated in any activities after 11/6/2024. The November 2024 Unit 1 and 2 Activity Calendar documented the following activities: - On 11/21/2024- AM: Resident Council; PM: Fall Craft - On 11/22/2024- AM: Nature Documentary; PM: Happy hour - On 11/23/2024- Coloring, Reading, Television, Phone Calls, Word puzzles, etc. - On 11/24/2024- Spiritual Care - On 11/25/2024- AM: Bingo (floor 2); PM: Thanksgiving craft - On 11/26/2024- AM: Bingo, PM: Music Therapy - On 11/27/2024- AM: Thanksgiving Parade; PM: Bowling - On 11/28/2024 there were no activities listed - On 11/29/2024- AM: Paint N' Sip; PM: Birthday Celebration - On 11/30/2024- AM: Coloring, Reading, Television, Phone Calls, Work puzzles, etc. The following observations were made of Resident #35 in their room in silence. There was no television, radio, books, newspapers, puzzles, or other activities/ personalization in their room other than one picture frame with personal pictures on their dresser: - On 11/21/2024 at 10:40 AM and at 11:31 AM, sitting up in their wheelchair next to the window looking straight ahead at the dresser. - On 11/26/2024 at 9:46 AM and 12:50 PM, sitting up in their wheelchair next to the window looking straight ahead at the dresser. Resident #35 stated they liked to play softball, but at the facility all there was to do was watch television. There was no television in the resident's room. - On 11/30/2024 at 9:29 AM, sitting up in their wheelchair next to the window looking straight ahead at the dresser. - On 12/2/2024 at 1:35 PM, lying on their back in their bed, awake, looking at the ceiling. The dry erase board in Second Floor unit hallway was observed: - On 11/26/2024 at 12:49 PM, the AM activity was listed as independent activity; the PM activity was listed as music, [NAME] and choir. - On 12/02/2024 at 1:36 PM, the AM activity was listed as calendar pass; the PM activity was listed as bingo prizes, taking down fall decor. (continued on next page)

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 12/03/2024 at 9:40 AM, the AM activity was listed as let's decorate for Christmas, there was no PM activity listed. During an interview on 12/2/2024 at 1:40 PM, Certified Nurse Aide #42 stated the daily activities were listed on the dry erase board in the hallway and there was an AM and a PM activity. Activities included movies in the common television room and church on the television in the common area on Sundays. There were some 1:1 visits, sometimes games. Resident #35 preferred to stay in their room. Their family brought cards in for them when they were on the First Floor. They had not seen the resident really do anything since moving to the Second Floor. The resident was assessed for what they liked to do when they first came in, they were not sure if they were ever reassessed. It was important for the resident to participate in activities because it got them out of their room, stimulated their brain, and allowed them to meet people. During an interview on 12/2/2024 at 1:50 PM, Certified Nurse Aide #10 stated there were activities during the week but there were not any on the weekends. There used to be weekend activities when there was more activities staff. The activities at the facility were lacking. The daily chronicles were passed out, but nobody helped the residents to read them. There were monthly birthday parties, but they were not actually a gathering, cake was just passed out. Bingo was the only activity on the Second Floor that was done away from the unit activity. All activities on the Second Floor were in the common television area. They had never seen Resident #35 do anything and was often in their room. They picked up their room and made their bed earlier today and there was nothing for the resident to do in their room, not even a television. Resident #35 often yelled out because they did not have anything to do and thought they should have activities that kept them occupied. During an interview on 12/2/2024 at 2:08 PM, Licensed Practical Nurse #35 stated the residents on the Second Floor mostly had dementia, so they only gathered in the common television area for activities. Residents that preferred to be alone were provided with music, movies, and magazines. They knew Resident #35 well. Resident #35 was lonely, and they always wanted someone to talk to them. They, and other staff, tried to make time to sit and talk with the resident. They never saw the resident do much of anything and had never seen them with a puzzle or a book. The activities department did 1:1 visits but they were not sure if the resident had any recently. It was important for Resident #35 to have activities for their social well-being, and this was their home. (continued on next page)

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 9:41 AM, the Director of Activities stated they were currently the only activities staff, and they were stretched very thin due to short staffing. There were two activities daily during the week and one was for the First Floor and one for the Second Floor. The First Floor had higher functioning residents so they could do more activities such as crafts, paint n' sip, and card games. Activities were done in the dining room. The Second Floor had more cognitively challenged residents, so they did sensory activities and alphabet games, and the activities on the Second Floor were held in the common television area. There were coloring pages and markers/ crayons in the common television area for the Second Floor residents. Today's activity was decorating the units. There was nobody from activities on the weekends. They expected nursing to follow the calendar on Saturdays and facilitate coloring, reading, watching television, and puzzle books. On Sundays, nursing staff was supposed to put a program called Spiritual Care on the television in the common area. Activities were important for the residents because they got bored, and some did not have any family contact. Resident #35 had regular visits from family, but they did not like to leave their room. They enjoyed 1:1 visits, musical activities, and looking at the birds. They were not sure the last time the resident had a 1:1 visit. 1:1 visits were important for Resident #35's psychosocial well-being. It was not fair Resident #35 did not have social interaction, they did not have a roommate, no decor on the walls, and nothing to do in their room. They should probably get a 1:1 visit daily but there was no activities staff. They thought all rooms should have a television and they did not know Resident #35 did not have one. They could put a radio in their room because the resident liked music. During an interview on 12/3/2024 at 1:28 PM, the Director of Social Work stated activities were important for the residents and kept their minds going, kept them stimulated, and broke up their day. There were not enough activities. The resident did like music activities. The resident benefitted from 1:1 activities such as manicures or just talking with someone and enjoyed watching television. They enjoyed talking with the resident and went in to talk with the resident last week. Before they left, they asked the resident if they wanted to watch television. They were not aware the resident did not have a television in their room and there was not much for them to do in their room. Resident #35 refused a lot of activities, sometimes they came out and sat in the common television area, but they got overstimulated in groups. The resident should still be invited and even just being invited could help their psyche and they would feel like they were not forgotten. 10NYCRR 415.5(f)(1)

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 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)

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 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)

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 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)

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 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)

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 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)

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 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)

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 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)

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 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 .

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 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)

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 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)

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 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)

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 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)

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 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)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on observations, record review, and interviews during the recertification and extended surveys conducted 11/21/2024-12/4/2024, the facility failed to ensure the residents' environment remained free of accident hazards 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 degree 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. Findings include: 42 CFR 483.470 (d)(3) PART 483-REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES 483.470 Condition of Participation: Physical environment. (d) Standard: Client bathrooms. The facility must ensure: (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 Fahrenheit. NYS Rules and Regulations, Article 2 Medical Facility Construction, Part 713- Standards of Construction for Nursing home facilities, Section 713-1.9- Mechanical requirements, (m) Domestic hot water systems shall provide adequate hot water at each outlet at all times. Hot water temperature at fixtures used by residents shall not exceed one hundred ten degrees Fahrenheit. The facility policy, Safety of Water Temperatures, revised 11/10/2024 documented the water heater that serviced resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of not less than 105 degrees Fahrenheit and no more than 120 degrees Fahrenheit. If the temperature of the water feels excessive to the touch, staff would report this finding to their immediate supervisor. Facility water temperature logs from 5/2023 to 11/21/2024 documented water temperatures as high as 140 degrees Fahrenheit on 1/5/2024 and 1/15/2024. Measurements of water temperatures on 11/21/2024 were as follows: - At 10:44 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 123.4 degrees Fahrenheit. - At 11:00 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 126.4 degrees Fahrenheit. - At 11:03 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 122.4 degrees Fahrenheit. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- At 11:10 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 129.8 degrees Fahrenheit. - At 11:18 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 129.6 degrees Fahrenheit. - At 11:21 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 130.5 degrees Fahrenheit. - At 11:33 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 132.4 degrees Fahrenheit. - At 11:41 AM, the shower water temperature by room [ROOM NUMBER] was measured at 129.9 degrees Fahrenheit. - At 11:49 AM, the shower water temperature by the nurse's station on the Second Floor was measured at 128.3 degrees Fahrenheit. - At 12:14 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 129.7 degrees Fahrenheit. - At 12:35 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 129.0 degrees Fahrenheit. - At 12:37 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 126.5 degrees Fahrenheit. During an interview and review of the air and water temperature logs on 11/21/2024 at 2:02 PM, Director of Maintenance #7 stated the typical water temperature was 125 degrees Fahrenheit. They had a thermometer that worked for measuring air and water temperatures. There were several days on the log sheet documenting water temperatures measuring at 130 degrees Fahrenheit. During an observation and interview 11/21/2024 between 2:05 PM and 2:29 PM, Director of Maintenance #7 verified water temperatures: - At 2:05 PM, the sink water temperature in the First Floor nourishment room was measured at 121.3 degrees Fahrenheit. - At 2:08 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 121.5 degrees Fahrenheit. - At 2:14 PM, the shower water temperature near the First Floor nurse's station was measured at 111.8 degrees Fahrenheit. - At 2:17 PM, the sink water temperature in the second-floor shower room near room [ROOM NUMBER] was measured at 120.7 degrees Fahrenheit. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- At 2:21 PM, the Second Floor shower near room [ROOM NUMBER] was measured at 121.3 degrees Fahrenheit. - At 2:23 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 120 degrees Fahrenheit. - At 2:26 PM, the sink water temperature in resident room [ROOM NUMBER] was measured at 123.2 degrees Fahrenheit. During an interview on 11/21/2024 at 2:14 PM, Resident #28 stated they received a shower earlier in the day. The certified nurse aide checked the temperature with their arm and then asked the resident to test the water with their arm. Resident #28 stated after testing the water on their arm it felt too hot. During an interview on 11/21/2024 at 2:29 PM, Director of Maintenance #7 asked what the water temperature should be, as they read an article that which said the water temperatures should be between 122 degrees Fahrenheit and 124 degrees Fahrenheit. Director of Maintenance #7 stated that the surveyor's thermometer and the facility thermometer were about 1-degree Fahrenheit difference, and they were surprised that the two (2) thermometers were that close in temperature, as the facility thermometer was very old. They stated the water came in the building from an outside boiler and went into the two 200-gallon holding tanks. There was no temperature monitoring for the holding tanks. They tested the water temperature daily before 6:00 AM, because they wanted the temperatures before staff did morning care and used water. Measurements of water temperatures on 11/22/2024 were as follows: - At 8:59 AM, the water temperature in resident room [ROOM NUMBER]'s sink was measured at 131.9 degrees Fahrenheit. - At 9:10 AM, the sink water temperature in the First Floor nourishment room was measured at 130.8 degrees Fahrenheit. - At 9:12 AM, the sink water temperature in the First Floor shower room near the nurse's station was measured at 128.1 degrees Fahrenheit. - At 9:13 AM, the shower water temperature in the First Floor shower room near the nurse's station was measured at 121.8 degrees Fahrenheit. - At 9:17 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 123.4 degrees Fahrenheit. - At 9:21 AM, the sink water temperature in resident room [ROOM NUMBER] was measured at 124.2 degrees Fahrenheit. - At 9:29 AM, the sink water temperature in the Second Floor shower room near room [ROOM NUMBER] was measured at 124 degrees Fahrenheit. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- At 9:32 AM, the shower water temperature in the second-floor shower room near room [ROOM NUMBER] was measured at 127.9 degrees Fahrenheit. During an interview on 11/22/2024 09:01 AM, the facility Administrator stated the proper water temperatures were 90 to 120 degrees Fahrenheit. They had not received any complaints about water temperatures being too high from staff, residents, or families. The maintenance department tested water temperatures every day at four (4) different locations in the facility, two (2) on both units and the same four locations were tested every day. Maintenance did not know how to adjust the temperatures and they referred them to the vendor. There was no place to document what maintenance did when they discovered temperatures out of range. If a resident was exposed to high water temperatures, they could get scalded, have reddened skin, pain, blisters, and burns. During an interview on 11/22/2024 at 9:01 AM, Physician #8 stated they were not aware of any resident complaints or injuries related to water temperatures. They were not sure what the proper water temperature range was and what temperature was considered too hot. Water that was too hot could cause superficial burns, skin breakdown, and pain. During an interview on 11/22/2024 at 9:02 AM, the Director of Nursing stated certified nurse aides checked the water temperatures by hand and used their own judgement. Any staff that used the water was responsible to ensure the water was at a safe temperature. Any concerns should be reported to their charge nurse or the Maintenance Director. It was important water temperatures were checked for resident safety and comfort. There was potential for burns if water was too hot. During an interview on 11/22/2024 at 9:17 AM, Director of Maintenance #7 stated the appropriate water temperature range was 90-120 degrees Fahrenheit. Water temperatures were checked daily. If the water temperature was too hot, the vendor should be contacted. They reviewed the log sheet from October-November 2024 and confirmed only two (2) of the past 34 measurements were below 120 degrees Fahrenheit. Residents could get burned with these temperature readings and they should have called the vendor to have the temperature adjusted but they did not. During an interview on 11/22/2024 at 9:30 AM, Maintenance Technician #9 stated water temperatures had been high for the past couple of months and may have increased a couple of degrees since then. Many of the temperatures on the temperature logs were too high. They notified Director of Maintenance #7 of any high temperatures but had not done so in a long time. They should have told the Director of Maintenance so they could have called the vendor and have it fixed. Those temperatures could burn residents and staff. 10 NYCRR 415.12(h)(l). ********** The facility was notified of the Immediate Jeopardy on 11/22/2024 at 1:58 PM. The Immediate Jeopardy was removed on 11/29/2024 prior to the completion of the recertification survey. The facility implemented the following to remove the immediacy: (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	- The facility had the vendor on site and the water temperature was reduced on 11/22/2024 at 1:30 PM. - The facility completed full house monitoring of temperatures twice per day, logs documented all temperatures were less than 110 degrees Fahrenheit. - The facility reviewed their policy for hot water and adjusted it to meet the requirement of 110 degrees Fahrenheit. - The facility provided in-service education to 89.8% of staff as of 11/29/2024 at 8:08 AM, with plans for ongoing education of staff not currently on the schedule, prior to the start of their next shift. - The survey team interviewed 12 staff from various disciplines, including the two maintenance staff during an onsite visit(s) 11/27/2024. All staff demonstrated knowledge of education provided regarding water temperatures.

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 48446 48895 Based on observations, record review, and interviews during the recertification and extended surveys conducted 11/21/2024-12/4/2024, 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, Resident #2's bed was against the wall, with one bed rail and no bracket to hold the mattress in place (mattresses with bedrails should have a bracket or device to hold the mattress on the frame and in place. This is the component that keeps the mattress snugly against the rail. The bracket could be a strap around the end. or an actual raised metal bar. Resident #14 had an air mattress with bilateral side rails that were not monitored to account for changes in air pressure of the mattress; Resident #46 had a bed rail on one side and no bracket to hold the mattress in place against the bedrail; and 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. Findings include: The facility policy, Bed Safety and Bed Rails, dated 8/2022, documented bed frames, mattresses, and bed rails were checked for compatibility and size prior to use. Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattress would leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system were within the safety dimensions established by the Food and Drug Administration. Maintenance staff routinely inspected all beds and related equipment to identify risks and problems including potential entrapment risks. The maintenance department provided a copy of inspections to the Administrator and reports results to the Quality Assurance and Performance Improvement Committee for appropriate action. Copies of the inspection results were maintained by the Administrator and/or Safety Committee. Bed rails were properly installed and used according to the manufacturer's instructions, specifications, and other pertinent safety guidance to ensure proper fit. For the purpose of the policy, bed rails included grab/assist bars. The use of bed rails was prohibited unless the criteria for use of bed rails had been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Other references used were U.S. Food and Drug Administration's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment and The Hospital Bed Safety Workgroup, and Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings. (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The undated bed manual, Drive Delta 1000, documented bed rail installation for half and full rail systems. Drive Medical (Manufacturer of bed) products were specifically designed and manufactured for use in conjunction with Drive Medical accessories. Accessories designed by other manufacturers had not been tested by Drive Medical and were not recommended for use with Drive Medical products. Even with bed casters properly locked, some flooring surfaces such as tile, would allow the bed to move under some conditions; the use on such surfaces must be evaluated by a care provider. Mattress must fit the bed frame and side rails snugly to reduce the risk of entrapment. The undated manual, SafetySure Transfer Handle for Spring Style Hospital Beds, documented with the entrapment diagrams, the mattress must stay in contact with Bed Assist Handle. Mattress position was the facility's responsibility to maintain. The U.S. Food & Drug Administration Bed Rail Safety, documented Recommendations for Health Care Providers about Bed Rails, updated: May 10, 2016, documented to follow the recommendations in their guidance Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 2006. Dimensional limits for entrapment Zones 1-4 to reduce the risk for entrapment. Zone 3 was the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and the degree of play from loosened rails. The recommendations were for a dimension of less than 4 3/4 inches because the head was presumed to enter the space before the neck. The Facility Wide Self-Assessment completed 1/16/2024 documented inspection records were available for the 80 electric beds in the facility. During observations on 11/21/2024, between 4:32 PM and 4:45 PM, 32 residents had bed rails on their beds. During observations on 11/22/2024 between 11:03 AM and 12:48 PM, bed entrapment zones were measured as identified by the U.S. Food and Drug Administration's Hospital Bed Safety Workgroup Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings using a bed system measurement tool. A total of five (5) beds were sampled (Residents #2, #14, #29, #33, and #46). All five (5) beds were out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail should be no greater than 4 and 3/4 inches). 1) Resident #2 had diagnoses including dementia, lack of coordination, and repeated falls. The 8/27/2024 Minimum Data Set assessment documented Resident #2 had severely impaired cognition, required partial assistance for all mobility tasks, and did not use bed rails. The Comprehensive Care Plan, initiated 3/16/2020 and revised 5/12/2021, documented Resident #2 was at risk for falls related to confusion, non-compliance with call bell use, and self-ambulation. Interventions included the left side of the bed against the wall per resident's choice. The 3/16/2020 comprehensive care plan, revised 6/20/21, documented Resident #2 had activities of daily living care plan related to confusion and impaired balance. Interventions included partial assist with bilateral bed enablers (bed rails). The following orders were documented by the Medical Director: (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- On 5/13/2021, bilateral mobility bars. - On 5/18/2021, left side of bed against the wall. - On 6/1/2022, border mattress (a mattress with curved raised sides) During an observation on 11/21/2024 at 11:05 AM, the left side of Resident #2's bed was positioned against the wall, there was a bed rail on the right side, and a border mattress in place. At 12:14 PM, Resident #2 was not in bed. The mattress moved on the frame and there was no bracket holding the mattress in place. There was room for the mattress to move towards the wall, allowing for a gap between the bed rail and mattress. During an observation on 11/22/2024 at 12:48 PM, the left side of Resident #2's bed was positioned against the wall, there was a bed rail on the right side, and a border mattress in place. The bed was measured with the bed rail measuring tool outlined in the Food and Drug Administration guidelines and found to be out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail was greater than 4 and 3/4 inches). There was no documented evidence alternatives to a bed rail were attempted, a bed rail assessment was completed prior to bed rail installation, risks and benefits of the bed rails were explained to the resident or their representative, consent was obtained prior to bed rail installation, and of ongoing monitoring of entrapment zones. 2) Resident #14 had diagnoses including multiple sclerosis (disease that affects the brain and spinal cord). The 8/16/2024 Minimum Data Set assessment documented Resident #14 was cognitively intact, dependent on staff for bed mobility, and did not use bed rails. The Comprehensive Care Plan initiated 7/25/2023 and revised 12/3/2021, documented Resident #14 had an activities of daily living self-care deficit. Interventions included the use of a bed trapeze (an overhead devise that assists with movement and transfers in bed). There was no care plan related to the use of bed rails. During an observation and interview on 11/22/2024 at 9:05 AM, Resident #14 stated their 1/4 bed rails were useless, and they could roll over the top of them easily. The resident stated they were not asked if they wanted them, there was no consent, and the facility did not do an evaluation with them on how to use them. The resident stated the facility put the rails on one day, they did not sign anything, and were not educated on the risks and benefits of the bed rails. The resident's bed was in the middle of the room with an alternating air mattress (a mattress that uses air cells that inflate and deflate in a pattern to relieve pressure points). During an additional interview on 11/22/2024 at 2:29 PM, Resident #14 stated that they nearly broke their arm in the bed rail. It got stuck and they did not have the means to move themselves. The bed was measured with the bed rail measuring tool outlined in the Food and Drug Administration guidelines and found to be out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail was greater than 4 and 3/4 inches). (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There was no documented evidence alternatives to a bed rail were attempted, a bed rail assessment was completed prior to bed rail installation, risks and benefits of the bed rails were explained to the resident or their representative, consent was obtained prior to bed rail installation, and of ongoing monitoring of entrapment zones. 3) Resident #46 had diagnoses including muscle weakness and dementia. The 9/4/2024 Minimum Data Set assessment documented Resident #46 had moderately impaired cognition, required maximum assistance for bed mobility and transfers, and did not use bed rails. The 2/26/2024 comprehensive care plan documented Resident #46 had activities of daily living self-care deficits. Interventions included a right-side bed enabler (bed rail). During an observation on 11/21/2024 at 12:38 PM, Resident #46 had a right-side bed rail in place. During an observation on 11/22/2024 at 12:42 PM, Resident #46 had a right-side bed rail in place with their bed in the middle of the room and a regular mattress. The mattress was not held in a bracket to the bed frame. The bed was measured with the bed rail measuring tool outlined in the Food and Drug Administration guidelines and found to be out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail was greater than 4 and 3/4 inches). There was no documented evidence alternatives to a bed rail were attempted, a bed rail assessment was completed prior to bed rail installation, risks and benefits of the bed rails were explained to the resident or their representative, consent was obtained prior to bed rail installation, and of ongoing monitoring of entrapment zones. During an interview on 11/22/2024 at 11:51 AM, Certified Nurse Aide #6 stated only certain identified residents who were able to use rails for mobility had rails on their beds. The Physical Therapy Department evaluated the residents and put rails on the beds and provided education regarding risks and benefits of the rails. They believed it was documented on the resident's care instructions in the mobility section by physical therapy. They were not sure how often residents were evaluated for appropriateness of rails and did not believe rails required a consent. During an interview on 11/22/2024 at 11:55 AM, Certified Nurse Aide #10 stated Physical Therapy evaluated the residents for use of side rails and, if recommended, maintenance applied them. They were unsure if education was provided to the resident or how often they were re-evaluated. They were not aware of any bed, any mattress, or any bed position that would make the use of a side rail inappropriate. During an interview on 11/22/2024 at 11:56 AM, Certified Nurse Aide #11 stated only identified residents had rails on their beds and it was documented in the resident care plan. They were not sure who determined which residents were appropriate for rails, or how often the appropriateness of the rails was assessed. They did not believe the bars required a consent. (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/22/2024 at 12:01 PM, Licensed Practical Nurse #15 stated only identified residents had rails on their beds and was documented in their care plan. They were not bed rails but mobility bars and required a physician order. They believed there was a paper completed by family, the physician, and the resident. The rails were placed by physical therapy or maintenance, and they believed Physical Therapy evaluated residents for appropriateness of rails quarterly. Education was provided by the Physical Therapy Department and Licensed Practical Nurse Assistant Unit Manager #16. During an interview on 11/22/2024 at 12:07 PM, Certified Nurse Assistant #12 Physical Therapy evaluated the residents for use of side rails and maintenance applied them. They used the care instructions to see if someone was supposed to have a side rail. Rails could go on any bed, with any mattress regardless of whether the bed was up against the wall. During an interview on 11/22/2024 at 12:07 PM, Director of Maintenance #7 stated they did not have any bed maintenance logs for the beds. They did not know of any measurements required for bedrails. They stated the bedrails in the facility did not have entrapment risk as they were not large enough. Once the bed rails were placed, they would check a day or two later to make sure they were still tight but did not observe or maintain the bed rails after that. They did not monitor the beds unless someone put in a work order for a broken bed. During an interview on 11/22/2024 at 12:08 PM, Licensed Practical Nurse Assistant Unit Manager #16 stated the bars on resident's beds were mobility bars. Physical Therapy evaluated every resident for appropriateness of the bars, and it was documented on the care plan by the registered nurse or physical therapy. They did not require a physician order. Maintenance attached the bars to the bedframe. Physical Therapy completed an evaluation and provided education about the bars; however, they were not sure where it was documented. Physical Therapy also showed residents how to use the bars, and there was no consent required. They were aware of the entrapment risk and discussed the risk with the family, however, did not document that in the record. During an interview on 11/22/2024 at 12:18 PM, Registered Nurse Assistant Director of Nursing #20 (also functioned as the Admissions and Minimum Data Set nurse) stated identified residents had enabler bars, and no residents had siderails. Physical Therapy determined which residents were appropriate for enabler bars and documented it in their notes. The physician ordered the bars based on Physical Therapy recommendations and a work order was completed. They were not sure if a consent was required, but it was discussed at every quarterly care plan assessment. There was no literature given to residents about risk/benefits of the rails, however, physical therapy discussed them with the resident. Registered Nurse Educator #21 just completed an in-service on entrapment with staff and posted on the units, but was not sure where specifically it was posted. During an interview on 11/22/2024 at 12:18 PM, Physical Therapist #17 stated they collaborated with nursing and determined if a resident would benefit from enabler bars and deemed appropriate for the bars. The Director of Rehabilitation placed the maintenance request and updated the care plan. A formal re-evaluation for enabler bars was only completed due to a change in function and they would be notified in morning report. They were not aware of routine reassessments being completed. Residents were assessed for bed rails, because of the risk for entrapment. They did not know if consent was obtained, if a physician order was needed, or if education regarding risks/benefits were discussed or documented. The Director of Rehabilitation was responsible for the paperwork pieces that were completed. (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/22/2024 at 12:20 PM, Licensed Practical Nurse #13 stated most residents had side rails. Physical Therapy evaluated the resident and if a side rail was recommended then maintenance applied the side rail. They did not think a physician's order was required or that residents were ever reevaluated for continued usage. They did not know where to look to see who was supposed to have a side rail(s) and did not know of any risks associated with side rail use. They had not received any education regarding side rail usage or risk for entrapment. They were unsure what a side rail entrapment was and thought it had to do with a resident falling out of the side of the bed. During a telephone interview on 11/22/2024 at 12:31 PM, the Director of Rehabilitation stated when a resident was admitted , they were assessed and if the physical therapist recommended enabler bars either to facilitate independence or participation, then an electronic maintenance request was completed. After the enabler bar was installed, they or nursing updated the care plan. They did not think the facility required an order or a consent. They stated risks/benefits including entrapment were discussed as part of the evaluation, but details were not documented. During an interview on 11/22/2024 at 12:34 PM, Registered Nurse Unit Manager #14 stated Physical Therapy evaluated the resident for the use of rails and provided the resident with risk versus benefit education. If recommended, maintenance applied them. They were unsure if an order was required or if a consent form was completed. They did not have access to any physical therapy documentation and the only way to know who was supposed to have rails was to ask therapy. They did not know if there was any education regarding entrapment or if there was ever a re-evaluation done to determine if continued side rail use was appropriate. During an additional interview on 11/22/2024 at 1:47 PM, Director of Maintenance #7 stated the facility only had two types of beds, the bariatric bed, and the bed in which the manual was provided. All beds with the high side rail were the same and matched the bed manual. During an interview on 11/22/2024 at 4:33 PM, the Administrator stated residents were evaluated by the interdisciplinary team for enabler bars used for mobility in bed and for transferring. Maintenance put on the rails and ensured there was no space for residents to get stuck. They were not sure if maintenance knew how to check the safety of the rail or to monitor them after installation. The Rehabilitation Department knew enabler bars required monitoring; however, they were not sure the Rehabilitation Department was monitoring them. Risks of enabler bar usage was falling over the bar, broken bones, choking, or head injuries. They were not sure if residents or families were educated specifically on entrapment, but risks and benefits were reviewed by the Rehabilitation Department and would be documented in a progress note. There was no consent required, but there should be a consent as it was the best way to ensure residents and families were notified of the risks and benefits of the bars. They believed the Rehabilitation Department reviewed alternate interventions prior to use of enabler bars. Reassessments should be done quarterly with care plan meetings and with any significant change in resident status. The enabler bars required a physician order. During an interview on 11/22/2024 at 4:46 PM, the Medical Director stated they were not an expert on bed rails and were not aware of anyone in the facility having them. They did not recall being approached about writing an order for a bed rail, being a part of conversations regarding bed rail usage, or being a part of an assessment to determine if a rail was appropriate. They stated they could not comment on whether a resident could become entrapped in a bed rail or what could happen to that resident if an entrapment occurred as they would need to see a specific situation arise to be able to comment. (continued on next page)

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10NYCRR 415.12(h)(1)(2) ********** The facility was notified of the Immediate Jeopardy on 11/22/2024 at 5:53 PM. The Immediate Jeopardy was removed on 12/2/2024 prior to the completion of the survey. The facility implemented the following to remove the immediacy: - The facility removed all bed rails from resident beds, except for three (3) residents who refused to have them removed. They implemented hourly checks for those residents. - The facility secured two additional beds to ensure the bed and rails met the manufacturers specifications. - The facility provided in-service education to 87.8% of staff as of 12/2/2024 at 9:01 AM, with plans for ongoing education of staff prior to the start of their next shift for those not currently on the schedule. - The survey team interviewed 14 staff members from various disciplines, including the two-maintenance staff during an onsite visit(s) on 12/2/2024. All staff demonstrated knowledge of the education provided regarding bed rails. 49448

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446 Based on observations, record review, and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for 3 of 4 medications carts (First Floor 1-2 and 3-4 carts and Second Floor 3-4 cart), and 2 of 3 medication rooms (First Floor medication room and Second Floor Omnicell room). Specifically, the First Floor medication room refrigerator temperatures were not consistently monitored; medications in First Floor carts 1-2 and 3-4 were expired; the First Floor room refrigerator had unlabeled multidose vial medications; and the Omnicell (medication storage tower) medication room and the First Floor 1-2 and Second Floor 3-4 medications carts were unlocked. Findings include: The facility policy, Storage of Medications, updated 9/2018, documented medications and biologicals were stored safely, securely, and properly per the manufacturer's recommendations or those of the supplier. The medication supply was only accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication supplies were locked when they were not attended by persons with authorized access. Outdated, contaminated, or deteriorated medications and those in containers that were cracked, soiled, or without secure closures, were immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if an order existed. All medications were maintained within the temperature ranges noted by the Centers for Disease Control. Refrigerator temperatures were kept 36 to 46 degrees Fahrenheit. The facility maintained a temperature log in the storage area and recorded temperatures at least once a day or in accordance with the facility policy. Certain medications such as multidose injectable vials required an expiration date shorter than the manufacturers date when opened and ensured medication purity and potency. UNLOCKED MEDICATION STORAGE The First Floor 1-2 medication cart was observed unlocked at the nurse's station: - on 11/21/2024 at 11:42 AM with two residents in the area. Licensed Practical Nurse #39 walked from the end of the hall (10 rooms or more away from the cart) and locked the medication cart. - on 11/21/2024 at 1:01 PM with three residents in the area. Licensed Practical Nurse #39 came from inside the supply room where the door was shut, crossed the hall, and locked the cart. - on 11/21/2024 at 1:59 PM with two residents in the area. - on 11/26/2024 at 12:00 PM, outside room [ROOM NUMBER]. Licensed Practical Nurse #39 was near room [ROOM NUMBER]. (continued on next page)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/30/2024 at 9:28 AM, the Second Floor 3-4 medication cart was in the hall unlocked. There was no nursing staff present. During observations on 11/25/2024 at 12:50 PM and 1:58 PM the Omnicell room on the Second Floor located off the common area was unlocked with residents sitting just outside the door watching television. During an interview on 11/25/2024 at 1:58 PM, Registered Nurse #21 stated the room with the Omnicell should be always locked. During an observation and interview on 11/25/2024 at 2:58 PM Licensed Practical Nurse # 35 stated the room on the Omnicell room was not considered a medication room, it was a storage room for the Omnicell, and residents were not able to get into the Omnicell. They stated there were medications in the refrigerator including insulin and the Second Floor had wandering residents and the room should be always locked for safety. Only nurses had the key to the room and if residents got medications stored in the room, they could get sick. During an interview on 12/03/2024 at 11:57 AM, Licensed Practical Nurse #40 stated they worked 11/30/2024 and was the only nurse working on the Second Floor. They stated they did not lock the medication cart when it was in the hall. The unit had wandering residents, and they should have locked the medication cart for the safety of the residents. The facility policy was to always lock the medication cart when not attended. EXPIRED MEDICATIONS During a medication storage observation and interview with Licensed Practical Nurse #40 on 11/22/2024 at 7:47 AM, the First Floor 1-2 medication cart had Lispro insulin with an opened date of 10/17/2024 and expiration date of 11/17/2024. Licensed Practical Nurse #40 stated they did not administer the insulin and was not sure if the resident received the insulin after it expired. They stated if the insulin was administered it might not be as effective. During a medication storage observation and interview with Licensed Practical Nurse #15 on 11/26/2024 at 10:48 AM, the First Floor medication cart 3-4 contained lispro insulin labeled as opened on 10/22/2024 and expired on 11/22/2024. Licensed Practical Nurse #15 stated lispro was last administered to the resident on 11/23/2024 by Licensed Practical Nurse #39. During an interview on 11/26/2024 at 10:51 AM, Licensed Practical Nurse #39 stated they worked the First Floor medication cart 3-4 on 11/23/2024. After looking in the electronic medical record they stated they gave the lispro insulin on 11/23/2024 to Resident #69. They went to the First Floor medication cart 3-4 and picked up the insulin dated opened 10/22/2024 and expired 11/22/2024 and stated that was the insulin they administered. They should not have administered the insulin because it was expired and might not be effective. They did not check the expiration date and should have. REFRIDGERATOR LOGS The November 2024 medication refrigerator log for the First Floor medication room had multiple blank spaces for the three times a day temperature documentation. (continued on next page)

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication storage observation and interview on 11/22/2024 at 8:12 AM, Licensed Practical Nurse #39 stated refrigerator temperatures were checked every shift by the nurse on medication cart 1-2 and documented on the medication refrigerator log to ensure temperatures were not too high or too low. If there were no documented temperatures for one entire day, the medication refrigerator was not checked and there was no way of knowing if the temperatures were within range for those timeframes. The refrigerator contained an unlabeled multidose vial of the flu vaccine. Licensed Practical Nurse #39 stated the flu vaccine should have been labeled because it was opened and was only good for 28 days. They stated most nursing staff put a 30 day date on the medication. They stated medications carts should be always locked for the safety of the residents. They worked 11/21/2024 on the First Floor medication cart 1-2 and walked away at times without locking the cart and they should have. It was against policy to leave an unlocked cart unattended and a safety concern if residents got into medications or needles. During an interview on 12/2/2024 at 1:11 PM, Assistant Director of Nursing #20 stated they expected medications to be stored safely and securely. Medications should not be administered when expired and all multidose vials should be labeled with the date they were opened and the expiration date. Medication refrigerator temperatures were monitored every day, every shift and documented on the medication refrigerator log to ensure medications were stored at the proper temperatures. If there was no date documented on the log for 24 hours there was no way to determine if the medications were within the proper temperature range. For the stabilization and efficacy of the medications the refrigerator temperatures had to be done every day and every shift. They stated they had wandering residents on both floors. They were not aware the door to the Second Floor Omnicell room and medication refrigerator was unlocked until they were notified by Registered Nurse #21 on 11/25/2024. They were notified the lock was broken. The door should not have been unlocked as it was a safety concern because the room contained medications. 10NYCRR 483.45 (g)(h)

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 50561 Based on observations, record review, and interviews during the recertification survey conducted [DATE]-[DATE] the facility did not store, distribute, and serve food in accordance with professional standards for food service safety in the main kitchen and for 1 of 1 resident (Resident #34) reviewed. Specifically, Resident #34's food was handled directly by staff without the use of gloves. In the main kitchen foods in the kitchen walk-in cooler were not properly labeled; floors had debris and uncleanable surfaces; there were unclean surfaces and equipment; walls were in disrepair; and the dishwasher sanitizer was not maintained at the vendor recommended level. Findings include: The facility policy, General Kitchen Cleaning Policy, dated ,d+[DATE], documented all food contact surfaces would be properly cleaned and sanitized. The undated facility policy, Food Storage, documented food would be kept safe, wholesome, and appetizing; food would be stored at appropriate temperature and by methods designed to prevent contamination or cross contamination; food would be dated as it was placed on the shelves; and all containers or storage bags must be legible and accurately labeled and dated. The undated facility policy, General Food Preparation and Handling, documented food items would be prepared to conserve maximum nutritive value, develop, and enhance flavor and keep from harmful organisms and substances and kitchen surfaces and equipment would be cleaned and sanitized as appropriate. The undated facility policy, Bare Hand Contact with Food and Use of Plastic Gloves, documented single - use gloves would be worn when handling food directly with hands to assure that bacteria was not transferred from the food handlers' hands to the food product being served. Bare hand contact with food was prohibited. 1) Resident #34 had diagnoses including moderate protein-calorie malnutrition. The [DATE] Minimum Data Set assessment documented the resident was cognitively intact and required set up assistance for eating. The [DATE] comprehensive care plan documented the resident was able to feed themself after tray set-up. During a lunch meal observation on [DATE] at 12:32 PM, Certified Nurse Aide #30 spread mayonnaise on Resident #34's sandwich and put the bread back on the remaining sandwich components with bare hands. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 2:04 PM, Certified Nurse Aide #30 stated they helped Resident #34 put condiments on their sandwich, as the resident needed assistance with that task, and always got a sandwich with lunch. If they helped a resident with their food, they should wear gloves. They stated they could not recall if they helped Resident #34 with their sandwich on [DATE], but they would have worn gloves. It was important to wear gloves due to cross contamination and germs. During an interview on [DATE] at 11:08 AM, Registered Nurse #21 stated they were the facility's infection control nurse. They stated the expectation for hand hygiene and food service was that hands were washed prior to serving food. Staff should wear gloves when handling food. 2) During observations in the main kitchen on [DATE] at 9:45 AM, the walk-in cooler had opened, undated bags of parmesan and Monterey cheeses; opened, undated packages of turkey bologna, genoa salami, and bacon; opened, undated containers of sour cream, dill aioli, and buttermilk ranch dressing; and an undated box of 13 tomatoes that had green, fuzzy material on them. On [DATE] at 11:21 AM, the following observations were made in the main kitchen: - the floor tiles in the dry storage room were chipped and strip molding not fully fastened to the floor. - the second dry storage room had onion skins and other food debris under the wire rack shelving. There were cobwebs and two mouse traps (one dated ,d+[DATE]) behind the entry door. - the microwave had red food splatter on all interior surfaces. - the wall under the 3 bay sinks had tiles missing exposing the wall studs. - the bag in box dispensing nozzle had a dried substance in it. - the exterior and interior of the drink cooler had dried splatters. - the area around the grease trap was soiled with food debris and dried splatters. During an interview on [DATE] at 10:01 AM, the Food Services Director stated the following: - The evening shift should mop the area around the grease trap daily; clean the refrigerators and interior of microwave daily; and sweep and mop all floors including behind doors daily. They stated it did not look like they had been doing any of that. - Any food that was opened should be dated with the month and day. Once opened it was good for three days except lunch meats and cheese which were good for 5 days. The tomatoes should have been removed from the cooler when the new ones were put in. The bacon should not be left exposed in a box. Expired, moldy, or exposed foods could pick up mold spores and if a resident ate them, it could cause them to become sick. - The tile under the 3 bay sinks was removed while investigating a leak and was never replaced and they thought a repair estimate was obtained months ago. (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Most drinks were poured from the bag in box system. At the end of the night, the nozzles were put in a bucket of hot water and soaked for ,d+[DATE] minutes. They stated the nozzles had gross, dried brown/pink/fuzzy debris that looked like mold. Clean nozzles were important because the juice that passed through those nozzles was contaminated, and if a resident drank it, it could make them sick. They stated drinks had been poured from those nozzles for lunch that day and because of the moldy nozzle, they directed all drinks for the upcoming meal be re-poured. - They checked the dishwasher sanitizer level every morning using test strips but did not document the result. The [DATE] Ecolab Installation and Operation Manual for the ES Series Door Type, Chemical Sanitizing, Single and Dual Rack Dish Machines documented the minimum chlorine required for Model ES4000 was 50 parts per million. The facility's dishwasher sanitizer level log was not available from the facility. During an observation and follow up interview on [DATE] at 10:48 AM, the Food Services Director cycled the ES400 model dishwasher then tested the water with a chlorine test paper. The result was between 100 and 200 parts per million. They were unsure what it was supposed to be but thought they were told between 100 and 200 parts per million. If the sanitizer was greater than 200 parts per million it could cause sickness, chemical burns, respiratory issues, and make residents sick. If the sanitizer was below 100 parts per million the dishes would not be sanitized, bacteria could remain on the dishes and cause residents to become sick. 10NYCRR 415.14(h)

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 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)

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 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)

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 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)

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 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)

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10 NYCRR 483.70(i)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48895 Based on observation and interviews during the recertification survey conducted 11/21/2024-12/4/2024, the facility did not ensure a safe, functional, sanitary, and comfortable environment for staff, visitors, and residents on 1 of 2 units (First Floor), and 1 of 1 resident (Resident #30) reviewed. Specifically, the large shower room on the first floor had a strong smell of feces, the bathroom located in the main hallway by the administrative office had a strong smell of urine, and Resident #30 was observed in a wheelchair that was in disrepair. Findings include: The undated facility policy, Resident Rights, documented all residents were provided a dignified existence. During an observation on 11/23/2024 at 10:16 AM, the large shower room on the First Floor had a strong smell of feces, the toilet was filled with brown liquid, and there were multiple small flying insects in the area. During an observation on 11/24/2024 at 3:17 PM, the First Floor large shower room had a strong urine and feces smell, the floor tiles under the toilet and under the shower bed were discolored. There were small flying insects around the toilet area. The November 2024 First Floor cleaning logs documented the large shower room was cleaned daily. During an observation on 11/26/2024 at 1:29 PM Resident #30 was sitting in their room in their wheelchair. Both arm rests on their wheelchair were missing plastic and the material underneath the plastic was exposed. During an observation on 12/2/2024 at 4:37 PM, the bathroom in the main hallway by the administrative offices had a strong urine smell. There was brown debris on the back of the toilet bowl and the back of the toilet seat rim. During an interview on 12/2/2024 at 1:50 PM, Housekeeper #27 stated housekeeping was staffed from 6:00 AM until 10:30 PM and was responsible for cleaning resident rooms, bathrooms, the nurse's stations, dining rooms, day rooms, and offices. Cleaning included sweeping, mopping, dusting, restocking toilet paper and paper towels, and emptying trash. After the cleaning was completed, they documented the room was cleaned on their daily log sheet. If a room had an odor that smelled like urine, they used a chemical in the toilet and asked the resident if they allowed an air freshener to be sprayed. They had noticed the large shower room had an odor as it was used frequently. When a room smelled like urine it was not homelike. During an interview on 12/2/2024 at 1:57 PM, Certified Nurse Aide #30 stated although anyone could clean a resident area, it was ultimately housekeeping's responsibility. They stated the large shower room was used frequently throughout the day to shower residents and when the door was closed it smelled musty. If a resident was in an area that had an unpleasant odor, it was not homelike. (continued on next page)

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/2/2024 at 2:09 PM, Licensed Practical Nurse #13 stated when they noted an unpleasant odor, they notified a certified nurse aide and asked them to check the resident for incontinence. They stated they did not go in the shower room often and was not aware of any odor in the shower room. If a resident area had an unpleasant odor, it was not homelike for the resident. During an observation and interview on 12/2/2024 at 2:23 PM, Certified Nurse Aide #31 stated when a resident's wheelchair arms rests were worn and torn, they called maintenance and had them replaced. They could not recall anyone on the unit having arm rests on their wheelchair that were worn or torn. Certified Nurse Aide #31 observed Resident #30's wheelchair and stated the arm rests were missing plastic and exposed the material underneath the plastic. The arm rests should have been replaced. During an observation and interview on 12/2/2024 at 2:29 PM, the Director of Rehabilitation Services #18 stated when wheelchairs were in disrepair, they notified maintenance and completed a work order for repair or replacement. If a resident was in a chair that was in disrepair it was not dignified. During an interview on 12/2/2024 at 2:48 PM, the Director of Housekeeping #32 stated they expected rooms to be clean and free from odor. They reviewed the cleaning logs from each housekeeper every day to see if a room was not cleaned. If a room was not cleaned it was passed on to the next shift to clean. If there was an odor from a resident room they identified where the smell originated. They made rounds daily to make sure all areas were clean and free from odor. If a resident was in an area with an unpleasant odor, it was not homelike. If they noticed a wheelchair was in disrepair they entered a work order in the computer for maintenance to repair. During an observation and interview on 12/3/2024 at 8:12 AM, Director of Maintenance #7 stated work orders were completed electronically and directions were located at the nurse's stations. Work orders were typically completed the same day as they were submitted. If wheelchair arm rests were worn, torn, or in disrepair they were replaced the same day. If a resident had wheelchair arm rests that were worn, torn, or in disrepair the resident could feel embarrassed or uncomfortable. 10 NYCRR 415.5(a)

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48895 Based on record review and interviews during the recertification and extended survey conducted [DATE]-[DATE], the facility did not ensure an effective training program for all new and existing staff was developed, implemented, and maintained based on the facility assessment for 4 of 5 staff (Licensed Practical Nurses #13, #16, #39, and #43) reviewed Specifically, there was no documented evidence Licensed Practical Nurses #13, #16, #39, and #43 had general orientation and required training in accordance with the facility assessment. Findings included: The Facility-Wide Self-Assessment completed [DATE], documented staff competency and care area requirements as identified in the Resident Population Assessment included incontinence/toileting program, dementia care, pressure ulcer prevention and treatment, technical skills, and pain management. Annual training requirements per regulatory authority and/or facility policy included job responsibilities and line of authority, facility policies and procedures, and other areas identified as areas of weakness during annual performance review/competency evaluation. The facility Administrator documented a nursing education policy was not available when requested. Nursing Staff Education folders were reviewed: - Licensed Practical Nurse #43, hired [DATE], did not have documented evidence of facility orientation or nursing competency for medication administration or pressure prevention and treatment. - Licensed Practical Nurse #16, hired [DATE], did not have documented evidence of annual nursing competency for medication administration or pressure prevention and treatment. - Licensed Practical Nurse #39, hired [DATE], did not have documented evidence of facility orientation or nursing competency for medication administration or pressure prevention and treatment. - Licensed Practical Nurse #13, hired [DATE], did not have documented evidence of annual nursing competency for medication administration or pressure prevention and treatment. During an interview on [DATE] at 2:41 PM, Licensed Practical Nurse #13 stated the Director of Nursing watched them administer medications when they first started. They stated the facility had in-service education, but they would just have a paper to sign. They were told to read the paper and sign, so they were not sure what the trainings were on. During an interview on [DATE] at 2:46 PM, Licensed Practical Nurse #43 stated they did not recall any formal paperwork or training, they worked alongside another agency nurse who showed them how they did things. They did not recall any formal training. (continued on next page)

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 9:09 AM, Licensed Practical Nurse #39 stated they may have received a packet about medication administration, but they did not look at it. They stated no one at the facility showed them how to do medication administration at the facility. They worked alongside another nurse for approximately 2 hours, from 6:00 AM until breakfast and then they were on their own. They stated they did not receive facility education for pain management, dressing changes, or pressure wound prevention. They were not observed by a facility nurse when completing a dressing change. It was important to get education on wound care, because without proper wound care the resident could get an infection, sepsis, or a worsening wound. They should review any specific policies for their facility regarding medication administration, but education for medication administration was not important as they knew medications and how to administer them from previous experience. During an interview on [DATE] at 9:40 AM, Licensed Practical Nurse #16 stated they completed a medication test when they were oriented [AGE] years ago, and it was not done annually. Medication storage was reviewed during their orientation as well. They stated they thought they were one of the few people that had a good orientation. The last education they had regarding pain management was with a different facility educator that had been gone about 8 years. They did not have competencies related to pressure wound prevention and treatment or medication administration annually. They were not sure if the facility staff and agency staff received the same training, but the facility staff oriented with another nurse on the unit. It was important to have education for medications as nurses should know what they were giving, and that it was administered correctly. During an interview on [DATE] at 9:58 AM, Registered Nurse #21 stated they were responsible for staff education in the facility. The documentation provided was all the training the staff had on file. If an audit or observation was done of a specific staff member it would be in their provided folders. Agency staff had the education they needed coming to the facility, and they spent a day on the unit. There was a checklist for easier flow of training, but it had not been done that way. They did not have a current orientation process when staff were hired. Medication administration observation was done between a newly hired and the floor nurse they were paired with. If the floor nurse noticed an issue, they notified them or the Director of Nursing. They stated they would then observe the nurse and provide re-education if needed. They were not sure if the floor nurses the new hires were paired with had formal competencies completed. They stated that formal competencies for dressing changes were not completed prior to direct resident care. There were no formal checklists or observation tools for medication administration unless they were conducting an audit, or they were made aware of an issue. Of the 5 nurses picked for review, none of them had formal medication administration observations completed. Registered Nurse #21 stated given there were no formal competencies, they could not ensure nursing skill competency prior to direct resident care. Medication administration education was important, so medications were administered appropriately, not expired, and were effective for the resident. It was important to have wound prevention and treatment education, so wounds did not develop. They stated they had a lot of work to do to ensure trainings met the facility assessment. The pieces that were required on the Facility Assessment were covered throughout the year. Depending on when staff were hired, they would not get all the pieces before direct patient care, but they tried to complete in-services within the first year to meet the assessment requirements. During an interview on [DATE] at 11:39 AM, the Administrator stated that all new hires had nursing competencies completed before resident care occurred. There was formal education for all new hires that was department specific, and the facility did in-service education for the mandatory education and areas they thought were needed. It had been a while since they last audited nursing education. (continued on next page)

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.26