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	02/06/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, observations and interviews conducted during the recertification survey, the facility failed to ensure residents were free from abuse for one (1) of two (2) residents (Resident #11) reviewed. Specifically, Resident #11 had multiple incidents of physical and verbal behaviors directed toward others and interventions to protect other residents from abuse by Resident #11 were not implemented.Findings include:The undated facility policy Resident Rights, documented residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation.The undated facility policy Residentˆtoˆ Resident Incident Policy & Procedure, documented a Residentˆtoˆ Resident Incident was any interaction between two (2) or more residents that involved (or had the potential to involve): aggressive or unwanted physical contact; verbal aggression, threats, intimidation; or behavior that created fear, disruption, or psychosocial harm. Additionally, both resident's care plans would be updated to include a behavior monitoring plan and interventions to prevent recurrence.The undated facility policy Dementia Care & Treatment Policy and Procedure, documented residents living with dementia would receive personˆcentered, evidenceˆbased care that promoted the highest practicable physical, mental, and psychosocial wellˆbeing, consistent with comprehensive assessment and care planning. The facility policy Develop and Implement Comprehensive Care Plan, dated 01/20/2025, documented each resident would receive a comprehensive, person-centered care plan that addressed their medical, nursing, mental, and psychosocial needs and interventions would be specific and individualized to address resident needs and promote their well-being.Resident #11 had a diagnosis of dementia with other behavioral disturbances and agitation. The 11/12/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, was independent for most activities of daily living, and had no behavioral symptoms.The 05/08/2025 Comprehensive Care Plan, revised 10/01/2025, documented the potential for physical aggression towards others. Interventions included keep the resident away from three residents (identified by initials only). There were no documented resident specific interventions how the resident would be kept away from the other residents. The 1/22/2026 Comprehensive Care Plan, revised 02/02/2026, documented the resident had the potential to cause harm to others due to impulsiveness. Interventions included a stop sign across their door to prevent others from wandering into their room.Nursing progress notes from 06/01/2025 - 01/22/2026 documented Resident #11 had multiple behaviors including verbal aggression towards staff and residents; physical aggression towards staff; aggression towards inanimate objects in the environment; taking other residents' food and drink; wheeling residents up and down the halls that did not want to be wheeled; pushing an unidentified peer into a wall; an attempt to tip a resident out of their wheel chair; and wandering into others rooms and taking items. Psychologist #19 progress notes documented the following Resident #11 behaviors:-on 06/02/2025 they were more confused, combative with staff and hoarding food.-on 07/28/2025 they scratched a nurse's face and put a footrest through a glass door and was taken to the hospital by the police.-on 09/24/2025 they hit two (unidentified) residents for no reason; had become more aggressive; and it was only a matter of time before they seriously hurt someone.-on 10/13/2025 they had escalating aggression.-on 11/24/2025 they continued to be spontaneously (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aggressive.-on 12/8/2025 they continued to impulsively strike out at people if corrected. Resident #11 was involved in the following resident to resident incidents:-on 05/21/2025 at 9:10 PM they slapped an unidentified resident on the left side of the face. -on 09/17/2025 at 6:20 PM they slapped an unidentified resident in the face-on 10/15/2025 at 4:45 PM they slapped an unidentified resident's hand and called them a dirty animal. -on 11/14/2025 at 4:00 PM, they struck an unidentified resident on their head with an open hand.-on 11/16/2025 at 8:50 AM they yelled at an unidentified resident and slapped their right hand. -on 11/20/2025 at 4:45 PM they yelled at and slapped an unidentified resident on their forehead.-on 01/21/2026 at 4:00 PM they slapped an unidentified resident in the face.There was no documented evidence that after each of these incidents the facility evaluated the effectiveness of the care plan interventions or provided immediate interventions to assure the safety of residents and the prevention of resident abuse. During the following observations the stop sign was not draped across Resident #11's door:-on 02/04/2026 at 2:03 PM; Resident #11 was in their room.-on 02/05/2026 at 1:29 PM.-on 02/06/2026 at 9:14 AM; Resident #11 was in their bed. During an interview on 02/06/2026 at 9:14 AM, Certified Nurse Aide #9 stated they tried to keep behavioral residents by the nurses' station to better monitor them. They were unaware of any specific, individualized interventions for behavioral residents. Resident #11's behaviors were triggered by food and when they were told they could not do something. Resident #11 was aggressive towards staff and residents, including Resident #67 and #14. They were not aware of a specific behavior plan and believed the only interventions to keep them and other residents safe were frequent checks. The stop sign was to prevent others from wandering into the resident's room and should be draped across the doorway not hanging on one side.During an interview on 02/06/2026 at 9:39 AM, Licensed Practical Nurse #10 stated interventions to prevent behaviors usually included keeping residents at the nurses' station, maintaining distance between the residents, and redirection. Resident #11 was triggered by being told they could not do something and had physical altercations with Residents #40, #14 and #67. The only interventions in place to prevent Resident #11's behaviors was a stop sign across their doorway and keeping those residents that were known triggers away from them. During an interview on 02/06/2026 at 10:12 AM and 01:53 PM, Registered Nurse Manager #8 stated behavioral care plan interventions were based on individual behaviors and were considered effective if the targeted behavior lessened. Resident #11 had known triggers including food and others wandering into their room. The resident had two physical altercations with Resident #14 because Resident #14 wandered into their room, and they were fixed on Residents #67 and #40 for a while. Interventions to prevent their behaviors and protect other residents included a stop sign across their door, frequent checks, maintaining space between them and other residents, and person-centered care plans. They felt Resident #11 was not as violent as they were when they first arrived and had been leaving Resident #67 alone.During an interview on 02/06/2026 at 12:39 PM, the Director of Nurses stated behaviors were managed in part through activities of choice, the psychologist, and dementia in-services. Behavior care plans should include individualized activities. Resident #11 hit staff and residents including Residents #67 and #14. Their known triggers included others wandering into their room and someone getting too close. Other residents were kept safe by keeping them in a high visual area and performing frequent visual checks. Care plan interventions were effective if the target behaviors had lessened. If not, then the interventions were either not effective or additional interventions were needed. Resident #11's behavioral care plan interventions were effective, but basic and not person-centered; the resident would benefit from person-centered interventions.During an observation and interview on 02/06/2026 at 02:03 PM, Resident #11 was in the television area with Resident #40 and suddenly started yelling, blah, blah blah then called Resident #40 a derogatory name before being redirected from the area by Registered Nurse Unit Manager #8. Registered Nurse Manager #8 acknowledged Resident #11's care plan documented an intervention to keep them away from Resident #40. They stated they did the best they could, and someone must have placed Resident #40 in the area and then Resident #11 entered. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interviews during the recertification survey the facility failed to ensure they assessed residents using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services not less frequently than once every three months for twenty-one (21) of twenty-one (21) residents (Residents #5, #6, #8, #12, #16, #19, #24 #29, #30, #31, #35, #53,#54, #56, #58, #59, #63, #65, #67, #69, #72) reviewed. Specifically, Residents #5, #6, #8, #12, #16, #19, #24 #29, #30, #31, #35, #53, #56, #58, #59, #63, #65, #67, #69, and #72's Minimum Data Set assessments were completed later than fourteen days after the Assessment Reference Date (the final day of the observation period to gather information about a resident's condition when completing the assessment).Findings included:The facility policy Minimum Data Set Assessment Policy, revised 06/2023 documented a registered nurse signed the completed Minimum Data Set assessment and the facility submitted completed assessments electronically per the Centers for Medicare and Medicaid Services.The Centers for Medicare/Medicaid Services Minimum Data Set Resident Assessment Instrument Version 3.0 Manual documented that comprehensive assessments must be transmitted electronically to the Quality Improvement Evaluation System Assessment Submission and Processing system using the Centers for Medicare/Medicaid Services wide area network within 14 days of the care plan completion date and all other Minimum Data Set assessments must be submitted within 14 days of the Minimum Data Set completion date. For the admission assessment, the Minimum Data Set assessment completion date must be not later than 13 days after the Entry Date. An Omnibus Budget Reconciliation Act assessment (comprehensive or quarterly) was due every quarter unless the resident was no longer in the facility. There must be no more than 92 days between Omnibus Budget Reconciliation Act assessments. Quarterly Assessments:1) Resident #5's 12/12/2025 Minimum Data Set assessment, Section Z documented the registered nurse Minimum Data Set coordinator, Assistant Director of Nursing #3, verified completion on 01/30/2026.2) Resident #6's 12/10/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 01/28/2026.3) Resident #12's 12/29/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.4) Resident #19's 12/30/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.5) Resident #24's 12/10/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.6) Resident #30's 12/13/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.7) Resident #31's 12/16/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 01/25/2026.8) Resident #35's 12/16/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.9) Resident #53's 12/13/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.10) Resident #54's 12/25/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/03/2025.11) Resident #56's 12/17/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.12) Resident #58's 12/25/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.13) Resident #59's 12/18/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.14) Resident #63's 12/27/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.15) Resident #65's 12/26/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.16) Resident #67's 12/13/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026.17) Resident #69's 12/20/2025 Minimum Data Set assessment, Section Z documented (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant Director of Nursing #3 verified completion on 02/02/2026.18) Resident #72's 09/04/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion 10/07/2025. Annual Assessment:1) Resident #16's 01/04/2026 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 01/28/2026.2) Resident #29's 12/06/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 01/26/2026. Significant Change Assessment:1) Resident #8's 12/27/2025 Minimum Data Set assessment, Section Z documented Assistant Director of Nursing #3 verified completion on 02/02/2026. During an interview on 02/06/2026 at 10:32 AM, Assistant Director of Nursing #3 stated they were responsible for completing the Minimum Data Set assessment which had to be completed within 14 days of the Assessment Reference Date. The Minimum Data Set assessments for Residents #5, # 6, #8, #12, #16, #19, #24 #29, #30, #31, #35, #53, #54, #56, #58, #59, #63, #65, #67, #69, #72 were not completed timely and they should have been. The sections of the Minimum Data Set assessment were not completed by the different departments in time. It was important for all Minimum Data Set assessments to be completed timely as it carried over information and drove the care plan.10 New York Codes, Rules, and Regulations 415.11(a)(4)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) meals reviewed (lunch meals on 02/05/2026 and 02/06/2026); seven (7) of seven (7) anonymous residents; and one (1) of one (1) resident (Resident #63). Specifically, food was not served at palatable and appetizing temperatures during the lunch meals on 02/05/2026 and 02/06/2026; seven (7) anonymous residents during a resident council meeting and Resident #63 stated the food did not taste good and was cold. Findings include:The facility policy Food Palatability Policy and Procedure, dated 03/2024, documented the facility would ensure all meals served were palatable, visually appealing, and met the dietary, cultural, and sensory needs of consumers, while maintaining compliance with food safety and quality standards. Food was flavorful, well-seasoned, appropriately textured and served at correct temperature for safety and enjoyment.The undated facility policy Food Temperatures, documented the food temperatures of all food items were taken and properly recorded prior to the service of each meal. All hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Cooking temperatures must be reached and maintained according to regulations, laws, and standardized recipes while cooking. Hot items may not fall below 135 degrees Fahrenheit after cooking, unless it was an item to be rapidly cooled below 41 degrees Fahrenheit and reheated to at least 165 degrees (for a minimum of 15 seconds) prior to serving. Caution should be taken to avoid serving food and liquids at temperatures that are too hot to avoid the risk of burns. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time was excessive, food should be transported using a method that maintained temperatures. During an interview on 02/02/2026 at 08:46 AM, Resident #63 stated the food did not taste good and was often served cold. It was not appetizing to look at. The toast was hard and cold, so cold butter could not melt on it when served and it tasted like cardboard. During an interview on 02/02/2026 at 08:39 AM, Resident #52 was eating breakfast in their room. They stated the food was always cold and did not taste good. During a resident council meeting on 02/02/2026 at 11:00 AM, seven anonymous residents stated the food did not taste good and was often served cold.During an observation on 02/05/2026 at 11:59 AM, Resident #52's meal was tested in the presence of Certified Nurse Aide #22, and a replacement tray was ordered. Food temperatures were measured as follows: hot dog 108.5 degrees Fahrenheit, creamed corn 102.6 degrees Fahrenheit, hot water at 122.7 degrees Fahrenheit, and juice at 54.7 degrees Fahrenheit. The hot dog was rubbery and chewy, and the creamed corn was not hot.During an observation on 02/06/2026 at 11:58 AM, the food cart arrived on the first floor and was placed near the nurses' station. During an observation on 02/06/2026 at 12:15 PM, Resident #36's meal tray was tested in the presence of Licensed Practical Nurse Assistant Unit Manager #23. The temperatures were measured as follows: crab pasta bake 106.7 degrees Fahrenheit, peas 123 degrees Fahrenheit, and hot water at 110 degrees Fahrenheit. During an interview on 02/06/2026 at 07:13 AM, Certified Nurse Aide #24 stated some residents said food did not look appetizing, while others said it was served cold and did not taste good. They offered to heat food in a microwave or get a replacement tray when residents complained.During an interview on 02/06/2026 at 10:11 AM, Licensed Practical Nurse #18 stated residents complained food did not taste good and was not served hot. Those complaints were from residents who did not eat in the dining room and there were no complaints from residents that ate in the dining room.During an interview on 02/06/2026 at 12:35 PM, Dietary Aide #25 stated they were responsible for ensuring meals trays were served at appropriate temperatures. Hot food should be served to the residents over 140 degrees Fahrenheit and cold food not over 40 degrees Fahrenheit so that it did not grow bacteria. They never heard residents complain about the food. The crab pasta bake served at 106.7 degrees Fahrenheit was warm enough for some residents and the hot dog served at 108.5 degrees Fahrenheit (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	felt warm to them. During an interview on 02/06/2026 at 12:40 PM, Food Service Coordinator #26 stated residents complained about the food. They attended care conferences where residents complained about breakfast food and food being cold. The complaints were mostly from residents who were served off hall trays and not in the dining room. They took the temperatures of all food before it was plated, and they expected hot dogs and peas to be served to the residents at 165 degrees Fahrenheit and crab pasta bake to be served to the residents at 155-165 degrees Fahrenheit. They stated kitchen staff delivered the cart with hall trays to the unit, and they did not know how long it took unit staff to deliver those tray to the residents. When residents complained of cold food, they offered a replacement or replated the item. Food served to residents should be palatable.10 New York Codes, Rules and Regulations 415.14(d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure food was stored, distributed and served in accordance with professional standards for food service safety for one (1) of one (1) main kitchen. Specifically, the main kitchen dishwasher's water temperature was not maintained at the vendor recommended level.Findings include:The 10/29/2007 Installation and Operation Manual for the ES-2000 and ES-4000 Series dishwasher documented the minimum water temperature required for Model ES4000 wash and rinse cycle was 120 degrees Fahrenheit.The 01/2026 facility's dishwasher sanitizer level log documented the water temperatures never reached 120 degrees Fahrenheit for either the rinse or wash cycle.During an observation and interview on 02/05/2026 11:02 AM, Food Service Worker #29 stated a water temperature below 100 degrees Fahrenheit was too low. The empty dishwasher was run, and during the wash cycle the temperature reached a high of 92 degrees Fahrenheit.During an interview on 02/05/2026 11:10 AM, Food Service Coordinator #26 stated they were told both the wash and rinse cycle water temperature should be 110 degrees Fahrenheit. They had to run the machine three times before it reached the acceptable temperature of 110 degrees Fahrenheit and did not run dishes through it until it reached that temperature. Temperatures were taken three times a day before washing dishes. During an interview on 02/05/2026 at 11:16 AM, the Director of Food Services stated they believed the dish machine wash and rinse temperatures should be 110 degrees Fahrenheit. The dish machine had to run empty a few times to get to that temperature before they could run dishes through it. They were aware the dishwasher water temperature logs recorded temperatures below 110 degrees Fahrenheit but was told by the outside vendor because the machine was a chemical sanitizing machine the water temperature could be as low as 75 degrees Fahrenheit and still be effective in sanitizing the dishes.During an interview on 02/06/2026 at 11:52 AM, the Director of Maintenance stated they were told by the outside vendor that although the current dish machine water temperatures were not optimal, it was still sanitizing. They were able to adjust the water temperature but based on what the vendor told them and because it could affect the water temperatures on the resident units, they had not adjusted the temperature 10 New York Codes, Rules and Regulations 415.14 (h)

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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. Based on record review and interviews during the recertification survey, the facility did not provide the appropriate liability and appeal notices to Medicare beneficiaries for 1 of 3 residents (Resident #33) reviewed. Specifically, Resident #33 remained in the facility after discontinuation of Medicare Part A services, and the facility did not provide the resident with a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (Centers for Medicare and Medicaid Services-10055) as required. Findings include:The facility policy, Medicare Beneficiary Notices: NOMNC (CMSˆ10123), DENC (CMSˆ10124), SNF ABN (CMSˆ10055) & ABN (CMSˆRˆ131), dated 11/23/2025, documented when a resident on Part A services had days remaining, but was being cut, and remained in the facility under custodial care, they must be provided with a Notice of Medicare Non-coverage and a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The Notice of Medicare Non-Coverage documented the last covered day of Resident #33's Medicare Part A skilled services was 08/26/2025. The notice was signed by Resident #33's representative on 08/22/2025.There was no documented evidence the facility provided Resident #33 a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (Centers for Medicare and Medicaid Services CMS-10055) for Medicare Part A as required.The Skilled Nursing Facility Beneficiary Protection Notification Review process documented the resident's Medicare Part A skilled services start date was 07/18/2025 and the last covered day of Part A service was 08/26/2025. Medicare Part A Service Termination/Discharge Determined box checked the facility/provider initiated the discharge when benefit days were not exhausted. There was no documentation of the Skilled Nursing Facility Advance Beneficiary Notice (Centers for Medicare and Medicaid Services Form 10055) being issued to Resident #33 timely. The explanation for why the form was not provided box was checked as other. A typewritten note on the form indicated delayed notification Additionally, a handwritten note stated [Social Work] issued a delayed notification Skilled Nursing Facility Advanced Beneficiary Notice for this resident who remained in the facility. A delayed verbal notification was given to Resident #33's representative on 02/02/2026.During an interview on 02/05/2026 at 11:27 AM, Director of Social Work #31 stated Centers for Medicare and Medicaid Advance Beneficiary Notice of Non-Coverage Form 10055 should have been provided to Resident #33 at the same time the Notice of Medicare Non-Coverage was provided; however, it was not. Director of Social Work #31 stated this was an oversight they took responsibility for. Director of Social Work #31 stated the resident or resident representative should have been provided 48 hours' advance notice of service discontinuation; of their right to appeal; and the process to appeal the decision. They stated if a resident was not provided a Notice of Medicare Non-Coverage or a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage, they would not know their appeal rights and may have a potential loss of benefits or incur a financial liability.During an interview on 02/05/2026 at 11:24 AM, Administrator #1 stated issuing of the Notice of Medicare Non-Coverage (Center for Medicare and Medicaid Services-10123), and the Centers for Medicare and Medicaid Advance Beneficiary Notice of Non-Coverage Form 10055 were important documents for residents to receive timely because it has to do with the resident's right to appeal. A delayed receipt could deny resident's rights to appeal a decision, and the resident could end up making payment for services they aren't obligated to make.10 New York Code Rules and Regulations 483.10 (g) (18)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure the accuracy of resident assessments reflective of the resident's status during the observation period of the Minimum Data Det assessment for two (2) of two (2) residents (Residents #5 and #48) reviewed. Specifically, Resident #5's 12/12/2025 Minimum Data Set assessment did not include the use of oxygen or a noninvasive mechanical ventilator; and Resident #48's 11/10/2025 Minimum Data Set assessment inaccurately documented the resident was rarely understood and had moderate cognitive impairment.Findings include:The facility policy Minimum Data Set Assessment Policy, revised 06/2023, documented the Minimum Data Set was an assessment system that was comprehensive, accurate, standardized, and reproducible for each resident.1) Resident #5 had diagnoses including congestive heart failure, chronic respiratory failure, and morbid obesity. The 12/12/2025 Minimum Data Set assessment documented the resident was cognitively intact, was not on oxygen, and did not have a noninvasive mechanical ventilator.The 11/26/2025 Comprehensive Care Plan had no documented evidence that the resident was on oxygen or required a continuous positive airway pressure device at bedtime.The 06/03/2025 Provider #4's order documented two (2) liters of oxygen via nasal cannula to maintain oxygen saturation levels at 90% and change the oxygen tubing weekly.The 08/11/2023 Provider #4's order documented to monitor the resident's continuous positive airway pressure device (used to keep the airway open during sleep) and continuous positive airway pressure device was to be worn at bedtime.During an observation on 02/02/2026 at 08:56 AM Resident #5 was in bed with oxygen on at two (2) liters via nasal cannula.During an observation on 02/06/2026 at 6:34 AM Resident #5 was in bed wearing their continuous positive airway pressure device mask over their nose and mouth. During an interview on 02/06/2026 at 11:30 AM, Assistant Director of Nursing #3 stated they were responsible for ensuring completion and accuracy of the resident's Minimum Data Set assessments. The purpose of the Minimum Data Set assessment was to review resident circumstances and develop a care plan. There was a section in the Minimum Data Set assessment to indicate oxygen. Resident #5 was on oxygen and used a continuous positive airway pressure device. Oxygen and continuous positive airway pressure device use were not documented on their current Minimum Data Set assessment and should be.2) Resident #48 had diagnoses including multiple sclerosis (progressive neurological disease) and schizoaffective disorder (mental health mood disorder). The 11/10/2025 Minimum Data Set assessment documented the resident was rarely understood, had moderate cognitive impairment, had no evidence of acute change in mental status from baseline and was assessed by the Assistant Director of Nursing #3.The 08/10/2025 Minimum Data Set assessment documented Social Worker #21 had assessed Resident #48 to have intact cognition. There was no documented evidence in the care plan that Resident #48 had impaired cognition.The 12/23/2025 Social Worker #21's Social Service assessment documented throughout the interview, Resident #48 had intact cognition.During an interview on 02/05/2026 at 10:06 AM, Assistant Director of Nursing #3 stated they were responsible for completing the Minimum Data Set assessment however, Social Worker #21 conducted the brief interview for mental status assessments (indicator of cognitive status).During an interview on 02/05/2026 at 10:14 AM, Social Worker #21 stated they conducted the brief interview for mental status assessments. If a resident was unable to be understood, a staff assessment for cognition was conducted. Resident #48's 11/10/2025 Minimum Data Set assessment did not utilize the brief interview for mental status assessment and documented moderate cognitive impairment. The assessment was signed by Assistant Director of Nursing #3 and was not accurate, Resident #48 had intact cognition not moderately impaired cognition. They did not know why a brief interview for mental status was not conducted.During a follow-up interview on 02/05/2026 at 10:28 AM, Assistant Director of Nursing #3 stated they occasionally signed off assessments for other departments but never completed the assessments. They did not know why Resident #48's 11/10/2025 Minimum Data Set assessment documented the resident had moderately (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	02/06/2026

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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired cognition or why a brief interview for mental status assessment was not conducted. They stated it was their fault, and they must have clicked the answers in error. Resident #48 was not cognitively impaired.10 New York Code, Rules and Regulations 415.11(B)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice and the resident's physician orders for one (1) of one (1) resident (Resident #5) reviewed. Specifically, Resident #5 used a continuous positive airway pressure machine (delivers a continuous flow of air to open the airway) and oxygen that were not included on the care plan or the Minimum Data Set (an assessment tool); and the resident had an unclean continuous positive airway pressure mask. Findings include: The undated facility policy Oxygen Use, documented the facility ensured safe, compliant oxygen therapy through detailed procedural controls, staff training, equipment maintenance, and rigorous safety precautions. The provider order included the flow, humidification, targeted oxygenation level, and titration parameters. The Registered Nurse verified the order in the electronic medical record, checked contraindications, and posted an oxygen in use sign. Oxygen levels were checked every shift and as needed when there was a change in condition. The undated facility policy Use of [bilevel positive airway pressure/continuous positive airway], documented the facility was to ensure masks, machines, concentrators, nebulizer equipment, and tubing was sanitary to prevent transmission of potential pathogens within the facility. The mask was to be wiped with a clean washcloth, and the water chamber emptied daily. Every week the mask and headgear were soaked with mild soap and water for 30 minutes and air dried on a paper towel. Resident #5 had diagnoses including respiratory failure, chronic obstructive pulmonary disease (restrictive airway disease), and congestive heart failure. The 12/12/2025 Minimum Data Set assessment documented the resident had intact cognition, was dependent for most activities of daily living, and did not use oxygen therapy or a continuous positive airway pressure machine. The 08/11/2023 Physician #4's order documented continuous positive airway pressure machine use at bedtime and document refusals in a progress note. The 06/03/2025 Physician #4's order documented oxygen two (2) liters via nasal cannula to maintain oxygen saturations of 90%. Change tubing weekly. The 08/04/2020 Comprehensive Care Plan, updated 09/04/2025, did not include the resident's respiratory status or use of oxygen or a continuous positive airway pressure machine. The 02/2026 Medication Administration Record documented: -oxygen at two (2) liters via nasal cannula to maintain oxygenation of 90% checked every shift. -change oxygen tubing and clean filter on concentrator every week.-continuous positive airway pressure at present settings on at bedtime, document refusals in a progress note every evening.-Monitor continuous positive airway pressure, use five (5) times a day during hours of sleep documented at 8:00 PM, 10:00 PM, 12:00 AM, 02:00 AM, and 4:00 AM Resident #5 was observed receiving oxygen therapy at two (2) liters via nasal cannula:-on 02/02/2026 at 8:56 AM-on 02/04/2026 at 12:09 PM -on 02/05/2026 at 9:54 AM During the following observations the continuous positive airway pressure mask had white debris inside the mask: -on 02/02/2026 at 8:56 AM. -on 02/04/2026 at 12:09 PM. -on 02/05/2026 at 9:54 AM. Resident #5 stated they used the continuous positive airway pressure machine every night with the mask covering their mouth and nose. They had never seen staff clean their mask and would like it cleaned as they drooled in the mask when they were sleeping. During an observation on 02/06/2026 at 6:34 AM, Resident #5 was in bed wearing their continuous positive airway pressure mask over their nose and mouth. During an interview on 02/06/2026 at 6:11 AM, Certified Nurse Aide #6 stated Resident #5 wore oxygen and utilized a continuous positive airway pressure machine overnight. During an interview on 02/06/2026 at 6:14 AM, Licensed Practical Nurse #7 stated they looked at the care plan when determining each resident's specific care and the care plans were completed by the registered nurse. Oxygen therapy and use of a continuous positive airway pressure machine required a physician's order. Once ordered by the physician it was added to the care plan and populated to the medication administration record. The medication administration record notified the nurse when to monitor the resident's oxygen level and when to change the tubing. Additionally, it documented placement of the continuous positive (continued on next page)

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	335658	A. Building B. Wing	02/06/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	airway pressure machine at bedtime and monitoring of therapy every two (2) hours overnight. There was no place on the medication administration record to document adding distilled water to the chamber. They were not sure if there was an order to clean the mask as that was done by the day shift when the mask was removed. They assisted Resident #5 apply their face mask the previous night and did not notice white debris in the mask. When the mask was not properly cleaned residents were at higher risk for respiratory infections. During an interview on 02/06/2026 at 10:11 AM, Licensed Practical Nurse #18 stated when a physician ordered oxygen therapy or used of a continuous positive airway pressure machine, the registered nurse unit manager and/or their assistant documented the order as complete. After completing the order, oxygen and continuous positive airway pressure use populated to the medication administration record so the nurse knew what was required for each resident. Care plans were completed by the registered nurse unit manager and outlined the individual care for each resident. If a resident required oxygen or use of continuous positive airway pressure therapy, it was documented on the care plan. Resident #5 wore oxygen and used a continuous positive airway pressure machine at night. The night shift placed the continuous positive airway pressure machine on the resident and signed after completion on the medication administration record. They never cleaned Resident #5's continuous positive airway pressure machine and was not sure what shift was responsible for cleaning the equipment; they deferred to the medication administration record. During an interview on 02/06/2026 at 11:30 AM, Registered Nurse #3 stated they completed the Minimum Data Set assessment. The purpose of the assessment was to document resident's medical needs and functional status for development of the care plan. The Minimum Data Set assessment drove the care. If a resident was on oxygen tit should be documented in the Minimum Data Set assessment, they were unsure if there was a section for use of a continuous positive airway pressure machine. They looked in the computer and stated Resident #5's most recent Minimum Data Set assessment did not document use of oxygen or continuous positive airway pressure therapy. They did not document the use of oxygen therapy because the resident refused oxygen and did not always wear oxygen. They should have documented the use of oxygen therapy since the resident wore oxygen at times. They did not document the use of the continuous positive airway pressure because they were taught continuous positive airway pressure was not used for oxygen recovery. Continuous positive airway pressure could not be used if the resident was short of breath. During an interview on 02/06/2026 at 10:21 AM, Registered Nurse Unit Manager #5 stated Assistant Director of Nursing #3 was responsible for completing the Minimum Data Set assessment. Registered Nurse Unit Manager #5 stated they were responsible for adding physician orders in the electronic medical record and completing the care plan. Both oxygen therapy and continuous positive airway pressure machines required a physician's order and were documented on the care plan. Oxygen use required monitoring oxygen use and oxygen saturation levels, weekly tubing changes for infection control purposes, and humidification; all of which were documented on the care plan and on the medication administration record. Use of a continuous positive airway pressure machine was documented on the medication administration record for application of therapy, monitoring of therapy throughout the night, and cleaning the face mask and tubing to maintain proper infection control practices. Resident #5 wore oxygen and used a continuous positive airway pressure machine at night. They stated those interventions were not listed on the care plan or the medication administration record and should be. They were not sure why respiratory therapy use was not listed in the care plan or on the medication administration record. 10 New York Codes, Rules and Regulations 415.25(a)(4)