STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335675	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James G Johnston Memorial Nursing Home	285 Deyo Hill Road Johnson City, NY 13790

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. 33421 48446 Based on record review and interview during the recertification survey conducted 5/28/2024-5/30/2024, the facility did not ensure a comprehensive, person-centered care plan was developed and implemented to meet a resident's medical and nursing needs for 1 of 1 resident (Resident #17) reviewed. Specifically, Resident #17 did not have a comprehensive, person-centered care plan that included anticoagulant (blood thinner) therapy. Findings include: The facility policy, Resident-Centered Standards of Care and Exceptional Care Planning, implemented 12/2014, documented the facility utilized standards of care and developed exceptional resident-centered care plans that were culturally competent and consistent with resident specific conditions, risks, needs, history, behaviors, preferences, and with current standards of practice to meet the residents medical, nursing, mental, and psychosocial needs. Resident #17 had diagnoses including atrial fibrillation (irregular heart rhythm with increased risk of strokes due to the formation of blood clots). The 5/13/2024 Minimum Data Set assessment (a health assessment tool) documented the resident had moderate cognitive impairment, had 1 fall since admission or prior assessment, and received an anticoagulant. The 8/16/2023 physician order documented apixaban (Eliquis, blood thinner) 5 milligram tablet by mouth two times per day for history of atrial fibrillation. The comprehensive care plan dated 9/1/2023 documented the resident had a self-care performance deficit with interventions to assist with hygiene and was at risk for falls. Interventions included to have the bed in low position and against the wall. The comprehensive care plan did not include the resident received anticoagulant medication, was at risk for bleeding, or any interventions related to the anticoagulant medication use. During an interview on 5/30/2024 at 9:23 AM, Certified Nurse Aide #6 stated they knew how to take care for a resident based on their plan of care. Residents on anticoagulants required monitoring and gentler handling, as they had a higher incidence of bleeding. The resident preferred longer fingernails and scratched themselves at times. The resident was also a fall risk. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 9:43 AM, Licensed Practical Nurse # 5 stated resident specific care instructions were documented on the residents' care plan which were completed by the Director of Nursing and the Registered Nurse Unit Manager. Licensed Practical Nurses were not allowed to document on the care plan. If a resident was on an anticoagulant they required a soft bristle toothbrush, monitoring for bleeding, weekly skin checks, labs for certain anticoagulant medications, and sometimes would have protective sleeves to prevent skin tearing. During an interview on 5/30/2024 9:52 AM, Licensed Practical Nurse #4 stated resident specific care was documented in the resident care plan. The care plan was usually written and updated by the Registered Nurse Unit Manager. If a resident was prescribed an anticoagulant, it should be documented on the care plan with interventions that included bleeding precautions, monitoring for bleeding, using electric razors, soft bristle toothbrushes, and may even be on fall precautions. Resident #17 was on an anticoagulant and it should have been listed on their care plan. During an interview on 5/30/2024 at 10:09 AM, the Director of Nursing stated resident specific care was documented in the care instructions and care plan usually by the Registered Nurse Unit Manager. The care plans were reviewed quarterly and with any changes. If a resident was on an anticoagulant, it should be noted on the care plan with interventions that included bleeding precautions. They stated Resident #17 was on an anticoagulant and it was not documented in the care plan and should have been. During an interview on 5/30/2024 at 10:36 AM, Registered Nurse Unit Manager #3 stated resident specific care was documented in the care plan which generated the care instructions for staff to follow. The care plans were written by the Director of Nursing or the Registered Nurse Unit Manager and reviewed quarterly and as needed during the Comprehensive Care Plan meetings. If a resident was prescribed an anticoagulant, it should be documented in the care plan for bleeding precautions. Resident #17 was prescribed an anticoagulant which should have been documented in their care plan and was not. 10NYCRR 415.11(c)(1)

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NAME OF PROVIDER OR SUPPLIER James G Johnston Memorial Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 285 Deyo Hill Road Johnson City, NY 13790	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34459 Based on observation, interview, and record review during the recertification survey conducted 5/28/2024 - 5/30/2024, the facility did not ensure food was stored and equipment was maintained in accordance with professional standards for food service safety in the main kitchen and 1 of 1 nursing unit (Unit 1). Specifically, in the main kitchen floors in the middle walk-in cooler and walk-in freezer were unclean and soiled with food debris; on Unit 1 the juice machine was unclean and soiled with food spillage; and food brought in from the outside was stored in the Unit 1 refrigerator and was not discarded within the required time frame. Findings include: The facility policy, Floor Cleaning dated 1/2019, documented coolers were swept and mopped daily but a heavy scrub was done biweekly, or as needed, on Fridays (delivery day) and was completed by assigned dietary aides and management staff. Equipment: During an observation on 5/28/2024 at 10:34 AM, the main kitchen floors in the walk-in freezer and center walk-in cooler were unclean and soiled with food debris. The walk-in cooler also had a jagged section of flooring between where the flooring panels joined (1 inch by 12 inches) that was unclean and holding food debris. During an interview on 5/28/2024 at 10:34 AM, the Food Service Director stated the floors should be cleaner and they would be cleaned. The floors should be swept daily and cleaned under no less than weekly. During an observation on 5/28/2024 at 11:35 AM, the Unit 1 countertop juice machine was unclean and soiled with food spillage. There was dried on sticky juice and syrup on the juice dispensing gun, in the holder, and on the countertop and was running down the face of the cabinet. During an interview on 5/28/24 at 11:36 AM, Certified Nurse Aide #8 stated unit juice machine was cleaned by dietary staff. They were not sure how often it was cleaned. During an interview on 5/28/2024 at 12:12 PM, the Food Service Director stated the juice machine was cleaned daily in the evenings. There were no cleaning logs available for the juice machine. During an observation on 5/29/2024 11:22 AM, the main kitchen floors in the walk-in freezer and middle walk-in cooler were unclean and soiled in the corners where the wall and floors met underneath the shelves. The caulked seams where discolored red and black along the perimeter. During an interview on 5/29/2024 at 11:22 AM, the Food Service Director stated they had not put in a work order for the section of floors that was chipped. They further stated the floors in the walk-ins had been cleaned and that was the best they could get them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit 1 Refrigerator: During an observation on 5/28/2024 at 11:35 AM, the Unit 1 nourishment refrigerator had a plastic container with resident food in it that appeared to be tuna fish. There was a label on the container with a resident's name and a date of 5/21. The policy Resident Safe Food Handling Guidelines for Food Brought from Outside was affixed to the outside of the refrigerator door and documented food items would be discarded after 72 hours unless a manufacture's date was on the item. During an interview on 5/28/2024 at 11:36 AM, Certified Nurse Aide #8 stated food should be labeled when put into the refrigerator for residents by whatever staff puts the food away. Anyone could discard food items when they are past the 3 days on the label. There was a microwave in the unit break room that staff could use to reheat food for residents. During an interview on 5/28/2024 at 12:12 PM, the Food Service Director stated the unit refrigerator should be stocked and cleaned by dietary staff. Foods brought in for residents should be labeled and dated by the staff that puts the food in the refrigerator. Any staff that noticed resident food with a date past 3 days should discard the food items. During an observation on 5/29/2024 at 9:40 AM, there was a brown paper bag with food items in it in the Unit 1 refrigerator. The bag was labeled with resident room [ROOM NUMBER] and dated 5/22/24. During an interview on 5/30/2024 at 10:48 AM, the Infection Control Nurse stated dietary staff looked through the unit refrigerator each morning. Foods brought in for residents should be discarded if past 72 hours of the labeled date. Foods should be discarded within 72 hours because of the risk of food borne illnesses. One of the food items was from a discharged resident and should have been discarded as the resident was no longer in the facility. The food items should have been discarded regardless of the reason. 10NYCRR 415.14(h)