STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335680	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Memorial Geriatric Center	2256 Burdett Avenue Troy, NY 12180

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on record reviews and interviews during the recertification survey, the facility did not ensure that each resident received an accurate assessment reflective of the resident's status at the time of the assessment including the correct coding for anticoagulants for 7 (Residents #s #12, 25, 52, 53, 57, 62, and 72) of 24 residents reviewed. Specifically, for (a.) Resident #s 12, 25, 52, 53, 57, and 62 antiplatelet medications were coded as anticoagulants in the Minimum Data Set (an assessment tool). (b.) for Resident #72, there was not documented evidence that the resident was on anticoagulant, but it was documented in the Minimum Data Set that Resident #72 was on anticoagulant. This is evidenced by: The Minimum Data Set 3.0 Resident Assessment Instrument Manual (v1.08) Errata (v2) effective 4/1/2012 stated the coding instructions in Section N had been amended to include N0410 E. Anticoagulant. Specifically, the coding instructions stated that antiplatelet medications such as Aspirin were not to be coded as anticoagulants. (https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/mds30-raimanual-v108-errata-v3.pdf) Resident #53 was admitted to the facility with diagnoses of anemia, hypertension, and personal history of transient ischemic attack (a brief stroke). The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment, could sometimes be understood, and sometimes understand others. It documented Resident #53 had received anticoagulants within the seven days of Minimum Data Set completion. A Physician's Order dated 5/10/2024 documented the resident was prescribed Aspirin 81 oral tablet chewable, give 1 tablet by mouth one time a day. A review of the resident's Medication Administration Record for May 2024 documented the resident was not prescribed anticoagulant medications. Resident #57 was admitted to the facility with the diagnoses of dementia, diabetes mellitus and hypertension. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderately impaired cognition, could be understood, and understand others. It documented resident had received anticoagulants within the seven days of Minimum Data Set completion. A Physician's Order dated 10/20/2023 documented the resident was prescribed Aspirin 81 oral tablet chewable give 1 tablet by mouth one time a day. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's Medication Administration Records for June and July 2024 documented the resident was not prescribed any anticoagulant medications. Resident #72 was admitted to the facility with the diagnoses of displaced fracture of seventh cervical vertebra (a spinal injury that can be caused by falls, motor vehicle accidents, violence, and sport activities), Alzheimer's disease, and type 2 diabetes mellitus. The Minimum Data Set, dated dated dated [DATE] documented the resident had received anticoagulants within the seven days of Minimum Data Set completion. There were no documented evidence of physician orders for anticoagulant or antiplatelet medications. A review of the resident's Medication Administration Records for April and May 2024 documented the resident was not prescribed any anticoagulant or antiplatelet medications. During an interview on 8/08/2024 at 2:00 PM, Minimum Data Set Coordinator #1 stated that the Minimum Data Set may not consider Aspirin as an anticoagulant, but it was used as an anticoagulant, so they were going to code it as such. During an interview on 8/08/2024 at 2:14 PM, Director of Nursing #1 stated they did not know why Aspirin was being coded on the Minimum Data Set as an anticoagulant and it was not supposed to be coded that way. 10 New York Codes, 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 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. 35228 Based on record review and interviews during a recertification survey, the facility did not ensure it developed and implemented a comprehensive person-centered care plan that included measurable objectives and timeframe to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident # 57) of 24 residents reviewed for comprehensive person-centered care plans. Specifically, Resident #57 was diagnosed with a urinary tract infection and prescribed an antibiotic. There was no documented evidence that a care plan was written that addressed the change in condition. This is evidenced by: The Policy and Procedure titled, Interdisciplinary Care Conference and Care Planning dated 6/27/2023, documented it was the facility's policy to develop a comprehensive resident centered plan of care within 14 days of admission. The care plan was to be updated quarterly and with any significant change thereafter. Resident #57 was admitted to the facility with the diagnoses of dementia, type 2 diabetes mellitus, and hypertension. The Minimum Data Set (an assessment tool) dated 7/01/2024 documented the resident had moderately impaired cognition, was understood, and could understand others. The Comprehensive Care Plan did not have documented evidence that a care plan for urinary tract infection or antibiotic use was developed and implemented. A Progress Note dated 8/05/2024 documented Resident #57 was diagnosed with a urinary tract infection. A Nurse's Note dated 8/05/2024 at 9:07 AM, documented Registered Nurse Unit Manager #1 spoke with the Nurse Practitioner and Levaquin (an antibiotic) was ordered for 3 days for a urinary tract infection. The family was aware. During an interview on 8/09/2024 at 10:30 AM, Registered Nurse #1 stated a care plan should be initiated when there was a change. They did not know why there was not a care plan for urinary tract infections or antibiotics use. During an interview on 8/09/2024 at 10:43 AM, Director of Nursing #1 stated when a resident had a new diagnosis like a new infection, a care plan should be initiated for it and discontinued when resolved. They stated unit managers were responsible for initiating and resolving care plans. 10 New York Codes, Rules, and Regulations 415.11(c)(1) 43805

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48744 Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions for 2 (Resident #'s 27, and 180) of 24 residents reviewed. Specifically, (a.) for Resident #27, Comprehensive Care Plan for medications was not reviewed and revised for a resident who required Guaifenesin cough medication, daily Aspirin for blood thinning, and Cepacol lozenge as needed for sore throat. (b.) for Resident #180, Comprehensive Care Plan for nutrition was not reviewed and revised to account for discontinuation of the weekly weights that were to be done on Mondays. This is evidenced by: A review of the policy titled Interdisciplinary Care Conference and Care Planning dated 11/28/2016 and last revised 11/2019, documented the facility would develop a baseline interdisciplinary, resident centered plan of care within 48 hours of admission, and a comprehensive resident centered plan of care within 14 days of admission and provide follow-up evaluation based on admission/readmitted s/or a significant change in condition. Additionally, the policy documented that the plan would include initial goals, physician orders, medications, dietary orders, therapy orders, social service and any applicable Preadmission, Screening, and Resident Review (PASRR) recommendations and that the plan would be updated quarterly and with any significant change thereafter. Resident #27 was admitted with diagnoses of Alzheimer's Disease (a degenerative memory disease), type 2 diabetes (an endocrine dysfunction that causes inaccurate bodily responses to sugar), and adjustment disorder with depressed mood (depression caused by the struggle to acclimate to a new environment). The Minimum Data Set (an assessment tool) dated 5/24/2024 documented that the resident was understood and usually understood others, was minimally cognitively impaired but required significant assistance for most activities of daily living. The Comprehensive Care Plan dated 4/24/2023, and last updated 8/02/2023, for immunity impairment did not document the need for Guaifenesin cough medicine or Cepacol lozenge, the signs and symptoms that would require the need for the medications, or any documented resolution of symptoms. The Comprehensive Care Plan for active bleeding risk dated 4/24/2023 and last revised 5/30/2023, documented the resident was at risk for bleeding related to the use of anticoagulant therapy for prophylactic therapy for cardiac disease, however the resident was not on anticoagulant therapy medications. The interventions listed documented to assess for bruising and bleeding due to Aspirin use, however aspirin did not qualify as an anticoagulant. Resident #180 was admitted with diagnoses including unspecified dementia (a degenerative neurological memory disease), unspecified severe protein-calorie malnutrition (severely poor nutrition), unspecified hydronephrosis (physical dysfunction of the flow of urine from kidney to the bladder which can lead to kidney damage). The Minimum Data Set (an assessment tool) dated 7/19/2024, documented the resident was sometimes understood and could sometimes understand others, was minimally cognitively impaired but required significant assistance for most activities of daily living. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan for nutrition initiated 4/06/2023 and last updated 7/06/2024 documented that the resident was at nutritional risk related with the resident's medical history. Goals included maintaining weight in a stable range of 126-136 pounds plus or minus 5%. Interventions included weekly weights on Mondays. Physician order dated 7/17/2023 documented that weekly weights were to be done every Monday. The order was discontinued 8/02/2023. The discontinuation of the weekly weight order was not reflected in any of the care plan revisions. During an interview on 8/09/2024 at 8:35 AM, Licensed Practical Nurse #4 stated care plans should be updated when there was a change in resident conditions or if medications were added or removed. Care plans were reviewed quarterly and annually. Resolved or discontinued focuses, goals, or interventions should come off the care plans. During an interview on 8/09/2024 at 8:50 AM, Registered Nurse Unit Manager #1 stated care plans should be updated quarterly, annually after the resident's care conference and whenever there were changes. If medications were changed, added, or removed, the care plan should reflect the change, or the care area should be removed if something was discontinued. During an interview on 8/09/2024 at 9:32 AM, Social Worker #1 stated for a long time it was them who was responsible for providing the baseline care plans to the resident or resident representative. They stated that they were the only Social Worker in the building and it was difficult for them to get them to the residents/representatives within 48 hours because they only work Monday - Friday. Social Worker #1 stated they spoke with the Director of Nursing regarding the limitations they were having, and a performance improvement plan was implemented (in 2024, did not have exact date) which made Nursing responsible for providing baseline care plans to the residents/representatives. During an interview on 8/09/2024 at 9:55 AM, Admissions Director #1 stated they would add to their care plan if a resident was on hospice. They stated the facility adds to the care plan if residents were admitted to or referred to Hospice. Earlier in the year, they noticed they had a problem with the resident's baseline care plans. There was no documentation in Point Click Care that care plans were sent to the family or return of documentation from the family after they signed it. The performance improvement plan was initiated in April 2024. Reevaluation of the plan was ongoing. They stated they did a care plan within the first few hours and made sure the Certified Nurse Aides were provided with the care plan, so they know what care the residents needed. All departments were required to complete their assessments to create the care plan. 10 New York Codes of Rules and Regulations 415.11(c)(2) (i-iii)

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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. 47140 Based on observations, record review and interviews during a Recertification Survey, the facility did not provide needed care and services that were resident centered and in accordance with professional standards of practice to meet each resident's physical, mental, and psychosocial needs for 1 (Resident #11) of 24 residents reviewed. Specifically, the facility did not identify, document, investigate or monitored bruises to Resident #11's bilateral upper extremities. Resident #11 was prescribed an anticoagulant (blood thinning) medication and was at risk for bruising. The is evidenced by: The Policy and Procedure titled, Skin and Wound Care, effective 5/13/2024, documented it was the policy of the facility to assess/inspect the resident's skin, to monitor closely for changes and to document any new skin issues promptly and accurately. Resident #11 admitted to facility with diagnoses which included dementia, facial weakness following cerebral infarction (a pathologic process that results in an area of necrotic tissue in the brain), and anemia. The Minimum Data Set (as assessment tool) dated 6/25/2024 documented the resident had severe cognitive impairment, could sometimes be understood, and could sometimes understand others. The Care Plan dated 12/18/2020, documented Resident #11 had an active bleeding risk related to the use of anticoagulant therapy. The resident was documented to be at risk for bruising and bleeding due to anticoagulant medication use. Interventions included that staff should monitor for complications of anticoagulant therapy, such as bleeding gums, vomiting, blood, excessive bruising, blood in urine or tarry stool. Staff were to report any fall or injury to physician. During an observation on 8/05/2024 at 11:47 AM, Resident #11 was observed to have multiple bruises to their left hand, wrist, (dark blue in color) and arm and a bruise on their right hand and lighter purple colored bruising to their right arm. Review of Skin Assessments and Nursing Progress Notes did not reveal documentation of the resident's bruises. Upon request, the facility could not provide documented evidence that the bruises had been identified, monitored or investigated. During an interview on 8/08/2024 at 11:10 AM, Licensed Practical Nurse #3 stated they had not noticed the resident's bruises previously but that any new bruises or injuries should be documented and investigated. They stated Resident #11 had behaviors that could contribute to bruises and would wear a protective sleeve on their left arm that was also intended to help with edema (swelling), but the resident would often remove the sleeve. They stated bruising should be documented and investigated to determine interventions to prevent further injuries. They stated that Resident #11 had cognitive impairments and would be unable to state how they were injured. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/08/2024 at 2:11 PM, Registered Nurse #2 stated bruising to a resident should be documented and investigated if the resident was unable to state what had happened to cause the bruises. They stated the purpose of an investigation would be to identify the cause of the injury to prevent recurrence. They stated they were unaware of Resident #11's bruises and that the resident could be resistive to care at times. They stated staff statements should be obtained for three shifts back prior to the observation of the injury to try to determine what may have happened or if there were any observed behaviors that could have caused the bruising. A Skin/Wound Note dated 8/08/2024 at 3:09 PM, written by Registered Nurse #2 documented that it was brought their attention that the resident had scattered bruising to the top of their left hand and small bruise was also noted to the resident's right hand which were of an unknown origin. The note documented the resident was prescribed blood thinning medication and had paper thin skin. The physician was updated. During an interview on 8/09/2024 at 1:04 PM, Director of Nursing #1 stated Resident #11 received anticoagulant medication and that any new bruises should be documented, monitored and investigated to determine what may have caused the bruises in order to enact interventions to prevent recurrence. They stated investigation of bruises of an unknown origin entailed getting statements from staff who worked within the 72 hours prior to the observation of the injury and try to determine how the resident may have been injured. They stated Resident #11's bruises were not documented before it was brought to their attention by this surveyor. They stated that head to toe skin checks should document any bruises, skin issues or anything that was different from the resident's baseline. 10 New York Codes, Rules, and Regulations 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47140 Based on observations, record review, and interviews during a recertification survey, the facility did not ensure the resident environment remained as free of accident hazards as possible for 1 (Resident # 19) of 3 residents reviewed for accident hazards. Specifically, on 6/10/2024 and 7/26/2024 Resident #19 was injured while nursing staff attempted to cut the resident's fingernails; there was no documented evidence completed incident and accident reports/investigations following the incidents and no interventions implemented to prevent recurrence after the first time the resident was injured. This is evidenced by: The Policy and Procedure titled Patient Safety Event Reporting effective 1/22/2021 documented the intent of the policy was to inform staff of the type of events and/or concerns about patient safety or quality of care to report, to achieve consistency in process and format for investigation, review, analysis and trending of patient events, and to identify opportunities to improve the quality of patient care and safety, systems/processes, and security practices. An Adverse Event/Patient Safety Event was defined as an unexpected occurrence which results in an adverse effect on the patient or had the potential for an adverse effect. A Root Cause Analysis was defined as a systematic process to determine the underlying reasons for a deficiency or failure. The Root Cause Analysis should pinpoint the special cause(s) in clinical processes and common cause(s) in organization systems and processes that were involved in the event and should identify improvements that could be made to avoid recurrences. The procedure included that the employee who discovered, witnessed or received notice of the event completed an electronic event report. Documentation of the event in the electronic event report system should be objective, stating facts of what occurred, any injury to the patient, what follow-up actions were taken to treat the patient and the results, response(s) or patient outcome(s) following the actions taken. Resident #19 admitted to facility with diagnoses which included dementia, facial weakness following cerebral infarction, and anemia. The Minimum Data Set (as assessment tool) dated 5/16/2024 documented the resident had cognitive impairment, could sometimes be understood, and could sometimes understand others. The resident was assessed to be dependent on the assistance of nursing staff to complete personal hygiene. A Skin/Wound Note dated 6/10/2024 documented a Certified Nurse Aide was cutting Resident #19's fingernails and the resident sustained a small laceration to the middle finger on their right hand. It was documented the Certified Nurse Aide stated the resident moved and pulled away just as staff was cutting the nail and they nicked the cuticle. The wound was cleansed, bleeding controlled, and a dry protective dressing applied. A Skin/Wound Note dated 7/26/2024 documented Resident #19's left thumb was nicked (cut) while staff were trimming the resident's fingernails, and the area was cleansed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon request, the facility could not produce documentation that the facility investigated the incidents during which Resident #19 was injured while having their fingernails trimmed nor that interventions to prevent recurrence had been implemented. During an interview on 8/08/2024 at 2:11 PM, Registered Nurse #2 stated Resident #19 had anxiety, a behavior of clenching their fingers and required coaxing (gentle) and encouragement to complete personal hygiene. They stated they recalled the first incident when Resident #19 was cut while having their nails trimmed but were unaware that it had happened twice. They stated they could not recall whether an incident and accident report had been completed when the resident was cut while having their fingernails clipped, however, that one should have been completed. They stated the purpose of completing an incident and accident report would be to identify interventions to prevent recurrence, identify areas for improvement and complete any needed education with staff on how to approach the task. The Activities of Daily Living Care Plan, undated, documented that Resident #19 was dependent on staff to complete personal hygiene, however, did not include person-centered interventions on how staff should approach performing activities of daily living with the resident, taking into consideration the resident's cognitive impairment, anxiety and behaviors. During an interview on 8/09/2024 at 1:04 PM, Director of Nursing #1 stated the facility did not complete an incident and accident reports during the two incidents when Resident #19 was cut while having their nails trimmed, however, that incident and accident reports should have been completed because the resident sustained injuries. They stated the reports should have been completed to determine a root cause and implement new approaches/interventions and provide any needed staff education. 10 New York Codes, Rules, and Regulations 415.4(b)

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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. 48744 Based on observation, record review, and interviews during the recertification survey, the facility did not ensure that a resident who needs required respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the resident's goals and preferences were provided by a qualified professional for the assessment, treatment, and monitoring of residents with deficiencies or abnormalities of pulmonary function for 1 (Resident #58) of 3 residents reviewed for respiratory care. Specifically, Resident #58's oxygen tubing was not labeled with the date and time it was changed in accordance with professional standards and facility policy. This is evidenced by: Resident #58 was admitted to the facility with the diagnoses of traumatic subarachnoid hemorrhage (bleeding on the brain), chronic respiratory failure with hypoxia (repeated shortness of breath), and type 2 diabetes mellitus (endocrine dysfunction causing issues controlling blood sugar levels). The Minimum Data Set (an assessment tool) dated 7/19/2024 documented the resident had some significant cognitive impairment, was sometimes understood, usually understood others. t. Additionally, the resident needed significant help with activities of daily living. The Policy and Procedure titled Oxygen Administration, dated 9/18/2017, documented that oxygen tubing should be changed weekly and as needed. A Physician order dated 11/03/2023 at 8:00 PM, documented oxygen delivered at 2 liters continuously. A Physician order dated 3/21/2024 at 11:00 PM, documented to change the oxygen tubing on concentrator and portable tank weekly, and label with date and initials. The Medication Administration Record for August 2024 documented that from 8/05/2024 to 8/09/2024 every two hours Resident #58's oxygen was checked and set at 2 liters. The Treatment Administration Record for August 2024 documented that Resident #58's oxygen tubing was changed on the concentrator and portable tank, labeled with date and initials on 8/01/2024 and on 8/08/2024. During an observation on 8/05/2024 at 12:00 PM, Resident #58 was noted to have 2 liters of oxygen being delivered by nasal cannula. The tubing used did not have any labeling documenting when the oxygen tubing was changed. During an observation on 8/07/2024 at 11:08 AM, Resident #58 was noted to have 2 liters of oxygen being delivered by nasal cannula. The tubing used did not have any labeling documenting when the oxygen tubing was changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/08/2024 at 9:00 AM, Resident #58 was noted to have 2 liters of oxygen being delivered by nasal cannula. The tubing used did not have any labeling documenting when the oxygen tubing was changed. During an interview on 8/09/2024 at 8:56 AM, Registered Nurse Unit Manager #3, stated oxygen tubing was changed and labeled on Thursday overnight shifts and as needed, for example if there was an infection control problem, like the tubing was dirty or was laying on the floor, the expectation was that new tubing would be acquired. 10 New York Codes, Rules, and Regulations 415.12(k)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48744 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice. Specifically, opened insulin pens had no open and/or expiration dates written on them. This was evident for 1 medication cart on [NAME] Unit out of 2 medication carts reviewed in the facility for medication storage. This is evidenced by: The facility's Medication Administration Policy and Procedure, effective [DATE] documented, the expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date should be recorded on the container. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the medication container. During an observation on [DATE] at 11:36 AM of a medication pass with Licensed Practical Nurse #2 on [NAME] Unit, it was observed that when Resident #34's insulin Aspart Flexpen was removed from the medication cart drawer, it was labeled with only the date opened. There was no expiration date noted on the label. During an interview on [DATE] at 11:36 AM, Licensed Practical Nurse #2, stated both the date opened, and date expired should be put on the sticker when a new pen was opened. Licensed Practical Nurse #2 stated they would get a new pen to administer Resident #34's insulin however Licensed Practical Nurse #2 stated they were going to wait to give the insulin because lunch had not yet been delivered and Licensed Practical Nurse #2 was concerned that lunch might be late. During a medication cart review on [NAME] Unit with Licensed Practical Nurse #4 on [DATE] at 9:12 AM, the following were observed: - Resident #34's insulin Aspart Flexpen with a sticker for date opened and date expired. The sticker did not document the open or expired date. - Resident #5's insulin Aspart Flexpen and Lantus SoloStar insulin pens were noted to have stickers without the date opened or date expired filled out. - Resident #27's insulin Aspart Flexpen and Lantus Solostar insulin pens were noted to have stickers without the date opened or date expired filled out. - Resident #58's Lantus SoloStar insulin pen was noted to have a sticker without the date opened or date expired filled out. (continued on next page)

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	335680	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Memorial Geriatric Center	2256 Burdett Avenue Troy, NY 12180

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on ,d+[DATE] at 9:12 AM, Licensed Practical Nurse #4, stated if they went to use any of the above referenced pens and found them not labeled as they were, they would not use them. Licensed Practical Nurse #4 stated they would try to determine when the pens were opened by looking at the Medication Administration Records and nursing notes. If they were not able to determine the date they were opened, they would go to their supervisor for advice. During an interview on [DATE] at 9:38 AM, Registered Nurse Unit Manager #4 stated insulin pens should be labeled when opened with the date opened and the expiration date. When told about the insulin pens found during the medication cart review, Registered Nurse Unit manager #4 stated they would be doing an educational in-service with the staff regarding insulin pen management. 10 New York Codes, Rules, and Regulations 415.18(d)

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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** 47140 Based on observations, record review, and staff interviews, the facility failed to ensure food was stored and served under safe and sanitary conditions to prevent the potential contamination of food and the spread of food-borne illness in one of one kitchen. Specifically, expired foods were not disposed of in a timely manner, the kitchen was not clean and sanitary, and dented canned foods were not removed from common stock. This is evidenced by: The Policy and Procedure titled Food Supply and Storage, last revised [DATE], documented that food, non-food items and supplies used in food preparation should be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The procedure included that most products had an expiration date. The words sell-by, best-by, enjoy-by or use-by should precede the date. Foods past the use-by, sell-by, best-by, or enjoy-by date should be discarded. The dry food storage procedure included that the facility should maintain a designated area for items that were damaged such as dented cans that were returned for credit. The Associate Daily and Weekly Kitchen Cleaning Schedule documented that the stove tops including the sides of front of the stove top was scheduled to be cleaned daily. The kitchen floors, walls and under equipment were scheduled to be cleaned weekly on Sundays. The following observations were made in the kitchen/ food storage areas on [DATE] at 9:00 AM: -Diced tomatoes and cucumber were labeled with a used-by date of [DATE]. -Baked potatoes were labeled with a use-by date of [DATE]. -Parsnips stored in a plastic container was labeled with two dates of [DATE] and [DATE]. -Six chicken patties were in a container covered with plastic wrap and labeled with a use-by date of [DATE]. -A container of shredded carrots was labeled with a use-by date of [DATE]. -A container of sliced cucumbers was labeled with a use-by date of [DATE]. -Fifteen tomatoes halves with parmesan cheese on top of the tomato halves were labeled diced tomatoes with a use-by date of [DATE] -Seven packages of meat were unlabeled. -An open packet of taco seasoning was on a shelf with no labeling/date of when it was opened. -A dented can of peaches was on the common stock rack in the dry storage room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A dented can of sliced beets was on the common stock rack in the dry storage room. -The wall next to the fryer had dark, greasy build-up which was also present on the floor next to the fryer and on the wall behind a storage rack containing clean pans. -There were areas of thick grime/build-up on the floors under the food preparation stations, ovens and sinks. -There was grease/build up on the handles and fixtures to the oven. -There was debris/build-up on the ice scoop holder/container. The following observations were made in the kitchen/ food storage areas on [DATE] at 11:25 AM: -Four lemons with brown spotting. -Two packages of cut lettuce with brown discolorations in the middle of the lettuce bunches. -A package of shredded green cabbage with a use-by date of [DATE] -Three packages of shredded red cabbage with a use-by date of [DATE]. -The wall next to the fryer had dark, greasy build-up which was also present on the floor next to the fryer and on the wall behind a storage rack containing clean pans. -The floor and area between the stoves had dark buildup/ grease/ food/ debris. -There were areas of thick grime/build-up on the floors under the food preparation stations, ovens and sinks. -There was grease/build up on the handles and fixtures to the oven. -There was debris/build-up on the ice scoop holder/container. During an interview on [DATE] at 2:11 PM, Dietitian #1 stated, per facility policy, all foods should that were past their use-by date should be discarded. They stated that produce should be inspected for spoilage daily and food items showing signs of spoilage should be discarded as needed. During an interview on [DATE] at 12:35 PM, Service Manager #1 stated the kitchen should be cleaned daily. They stated the facility maintained a cleaning schedule which outlined the duties of kitchen staff for maintaining a clean and sanitary kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:18 PM, Executive Chef #1 stated they would go through food storage each morning to discard of food items that were past the use-by date or that showed signs of spoilage. They stated that sometimes they would miss food items that should have been discarded. They stated they would remove dented cans from the general stock and move them to a different area for return. They stated dented cans needed to be removed and returned because damaged cans could have air pockets that could compromise the food inside. They stated the kitchen should be cleaned daily. They stated they had noted areas that had been missed during cleaning/mopping that were noted by this surveyor. They stated deep cleaning occurred on the weekends. 10 New York Codes, Rules, and Regulations 415.4(h) Chapter 1 State Sanitary Code Subpart 14

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47140 Based on observations and interviews during a recertification survey, the facility did not ensure to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the possible development and transmission of communicable diseases/illnesses. Specifically, the facility did not ensure staff completed hand hygiene when indicated during meal service. This is evidenced by: The Policy and Procedure titled Hand Hygiene/Artificial Fingernails, last revised 6/18/2024, documented the purpose of the policy was to prevent the direct or indirect spread of microorganisms via the hands of colleagues and healthcare workers who provided direct patient care. The procedure included that hand washing/hand antisepsis was indicated before and after touching a patient, before and after wearing gloves, before and after touching the patient's surroundings, before, during, and after preparing food, anytime hands were visibly soiled, after bodily fluid exposure risk from a patient or self (sneezing, coughing, blowing nose, etc.), when moving from patient care of a potentially contaminated body site to a clean body site, after skin to skin contact with a patient and before touching laptop or phone and after using the restroom. During an observation on 8/05/2024 at 12:55 PM, Certified Nurse Aide #2 was wearing surgical gloves while assisting residents with their lunch meals in the [NAME] dining room. They started to provide Resident #180 with feeding assistance, then stood up and delivered two other meal trays, then assisted Resident #27 to cut up their meal into smaller pieces, and then returned to provide feeding assistance to Resident #180. Certified Nurse Aide #2 wore the same pair of gloves and did not perform hand hygiene in between assisting residents or after touching trays/other items in the environment. During an observation on 8/05/2024 at 12:58 PM, Licensed Practical Nurse #2 was in the [NAME] dining room assisting residents with their lunch meals. Licensed Practical Nurse #2 pulled up their pants, touched their hair, touched a chair, and then sat down and began providing feeding assistance to Resident #20. Licensed Practical Nurse #2 was observed to scratch their arm and rest their head with their left hand while assisting the resident and then reached for a glass of milk and assisted the resident to take a drink. They then wiped the residents face with the resident's clothing protector. Licensed Practical Nurse #2 did not perform hand hygiene after touching their clothing, face, and hair before assisting Resident #20. During an observation on 8/05/2024 at 1:03 PM, Certified Nurse Aide #3 was seated at a table providing Resident #58 with feeding assisting and adjusted the resident's clothing protector and touched the resident's wheelchair while assisting them. They then assisted Resident #12, who was seated at the same table with set up of their meal. They then stood up and went over to Resident #27 who was coughing and rested their left hand on the top of Resident #27's wheelchair while speaking with them and then returned to provide feeding assistance to Resident #58 without perform hand hygiene between residents of after touching environmental surfaces. It was observed that there was one hand sanitizer dispenser in the dining room which was in the corner on the opposite side of the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/06/2024 at 12:23 PM, Licensed Practical Nurse #2 was assisting with lunch meal services in the [NAME] dining room. Licensed Practical Nurse #2 was observed to carry three plastic cups filled with beverages with their fingers touching the top/mouth of the cups and then delivered the cups to Resident #20, then they wiped their hand on their pants and picked up three more plastic cups while again, holding the cups from the top/mouth and delivered the three cups to Resident #180. They then picked up a tray and put it down before picking up three more plastic cups filled with beverages and delivered them to Resident #71. Licensed Practical Nurse #2 did not perform hand hygiene after touching their pants, touching items in the environment, between residents or before placing their fingers on the mouth/top of the cups. During an interview on 8/07/2024 at 10:45 AM, Certified Nurse Aide #2 stated they had received training on hand hygiene practices when they were in training but not recently. They stated that hand hygiene should be performed before and after they assisted residents if their hands became soiled or if they touched anything in the resident environment to prevent cross contamination. During an interview on 8/08/2024 at 11:23 AM, Certified Nurse Aide #4 stated hand sanitizer should be used between residents and after touching anything in the resident environment. They stated they previously worked in the kitchen, and as a kitchen staff member, they had received training on where to place their fingers when carrying cups and plates for best service practice and to prevent spread of germs. They stated they had not received the same education as a certified nurse aide. They stated hand hygiene should be done frequently to prevent spread of infections. During an interview on 8/09/2024 at 11:56 AM, Infection Preventionist #1 stated staff should perform hand hygiene if their hands become soiled while serving meal trays and in between residents. They stated all staff had received training in hand hygiene practices and they would perform audits of hand hygiene practices by observing staff. They stated that if staff were observed to not perform hand hygiene when indicated, the staff member would receive reeducation and would need to complete a return demonstration. They stated nursing staff had not received education on finger placement on plates or cups because it seemed to them to be common sense that cups and plates should not be carried with fingers touching areas that the resident would eat from or touch with their lips while drinking. They stated there was only one hand sanitizer dispenser in the dining room but that the facility could add more dispensers. During an interview on 8/09/2024 at 1:04 PM, Director of Nursing #1 stated hand hygiene should be performed between residents and after touching items/surfaces in the resident environment to prevent spread of infection/cross contamination. They stated all nursing staff had received education on hand hygiene. 10 New York Codes, Rules, and Regulations 415.19 (a) (1-3)