STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335683	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Absolut Ctr for Nursing & Rehab Westfield L L C	26 Cass Street Westfield, NY 14787

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43785 Based on observation, interview, and record review conducted during a Standard survey completed on 10/28/24, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (Resident #78) of one resident reviewed. Specifically, Resident #78 was observed with medications in their room and self-administered those medications without being evaluated as to whether they could safely do so. The finding is: The policy and procedure titled Self-Administration of Medications revised on 11/23/21, documented residents have the right to self-administration of medication if the interdisciplinary teams deem it clinically appropriate. Each resident is given a detailed explanation of the medications that they may self-administer, the reason for the medication, what to expect, and the possible side effects within their cognitive ability to understand. The medication shall be stored in a locked drawer. Staff re-evaluates the resident's knowledge by having the resident report their understanding of the information presented to them. The self-administration of medication is monitored by the Team Leader (nurse). The Team Leader documents accordingly on the electronic Medication Administration Record, generating a progress note after each self-administration medication. Continued approval of the self -administration of medication by the resident is dependent on the resident's compliance with physician orders and facility procedures. Resident #78 diagnoses included hemiplegia (paralysis on one side of body) affecting right dominant side, need for assistance with personal care, and generalized osteoarthritis (degenerative joint disease). The Minimum Data Set (a resident assessment tool) dated 9/12/24 documented Resident #78 was understood, understands, and had moderate cognitive impairment. The Comprehensive Care Plan with revision date of 3/6/24, documented Resident #78 was independent with decision making skills. Documented to offer choices related to care routine, such as meals, clothing and/or activities; provide information to make safe/independent decisions, and respect choices. There was no documentation that the resident self-administered medications or stored medications at the bedside. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Order Summary Report documented an active order dated 9/6/24 for Fluticasone Propionate Nasal Suspension 50 micrograms, 1 spray in each nostril at bedtime for rhinitis (inflammation of the mucous membranes of the nose). There was no physician's order for Resident #78 to self-administer medications and that medications were to be left at the bedside. There was no order for artificial tears (eye drops used for dry eyes). Review of Medication Administration Record dated 9/6/24-9/30/24 and 10/1/24-10/24/24, documented Resident #78 received Fluticasone Propionate Nasal Suspension 50 micrograms, 1 spray in each nostril at bedtime for rhinitis. The medication was initialed as being administered by nursing staff. There was no documented evidence that Resident #78 could or did self-administer their nasal spray. There was no documentation that artificial tears were administered. During an observation and interview on 10/22/24 at 8:54 AM, one bottle of opened Fluticasone Propionate Nasal Suspension 50 micrograms (used to treat rhinitis) in box from pharmacy labeled (delivered 9/6/24) with resident's name and directions; and one opened bottle of artificial tears half fluid ounce bottle observed with no pharmacy label on the tray table in the room next to the bed. Resident #78 stated they administered their eye drops every morning and night; and the nasal spray just at night to themselves per their preference. Resident #78 stated if they ran out the staff would bring them a replacement. Review of progress notes dated 9/2/24 through 10/25/24 documented no evidence that Resident #78 was assessed by the interdisciplinary team to self-administer medications. There was no documented evidence that self-administration of medication was monitored by the Team Leader and there was no progress note after each self-administered medication by the Team Leader per the facility policy. During an observation on 10/24/24 at 6:41 AM, Licensed Practical Nurse #7 was observed to enter Resident #78's room with medications to be received by mouth in a medication cup and a cup of water. Fluticasone Propionate Nasal Suspension and Artificial Tears remained on the resident's tray table in the room. Oral medications were administered and Licensed Practical Nurse #7 exited the room. No acknowledgement was made regarding the medications sitting on tray table. During an observation and interview on 10/25/24 at 11:33 AM-11:34 AM, the medications, Fluticasone and artificial tears remained on the tray table in Resident #78's room. Licensed Practical Nurse #2 stated residents were only able to self-administer medications if they were cleared to do so, this included eyedrops and nasal sprays. They stated residents were usually cleared by the medical provider and there needed to be an order to self-administer. Licensed Practical Nurse #2 stated Resident #78 had an order for Fluticasone nasal spray and the order did not indicate self-administration or to leave at bedside. Additionally, they stated medications should be kept in a drawer in a resident's room or in the medication cart for safety. During an observation and interview on 10/25/24 at 11:43 AM, Licensed Practical Nurse #2 verified and identified that Resident #78 had Fluticasone nasal spray and artificial tears on their tray table in room. Licensed Practical Nurse #2 stated that Resident #78 needed an order to self- administer medications. Additionally, they stated Resident #78 did not have an order for artificial tears and should have one. Licensed Practical Nurse #2 stated any medications a resident received should be prescribed by the medical provider and they considered artificial tears a medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 11:46 AM, Registered Nurse #2, Unit Manager, stated they weren't 100 percent sure if any residents on their unit self-administered medication. Registered Nurse #2 stated a resident's capacity would need to be checked, education would have to be documented, and an order would be needed to self-administer medications. They stated the medication nurses should be monitoring self-administration of medication to be sure residents administered the medication properly and as ordered. They stated the Registered Nurse Unit Mangers should over see that monitoring and documentation were completed for self -administration of medications. Registered Nurse #2 stated they were not aware that Resident #78 had medications on their tray table, and they should have been. Registered Nurse #2 stated medications needed to be stored in the nightstand drawer to keep out of reach of wandering residents on the unit. During an interview on 10/25/24 at 4:40 PM, Medical Doctor #1 stated there was a process for self-administration of medications and usually the nursing staff would have a conversation with them when a resident wanted medication left at bedside. During an interview on 10/28/24 at 2:03 PM, the Director of Nursing stated before a resident self-administered medication there should be education provided and nurse follow up. They stated it should be documented in the progress notes that instruction was given and that the resident was able to redemonstrate the ability to self-administer medication safely. The Director of Nursing stated there should be an order for all medications that were being self-administered so the nurses knew the medication was available in the resident's room and resident was self-administering. They stated nurses don't sign for medications that are self-administered but could not recall how the medication was then signed for. The Director of Nursing stated that all medication needed to be stored safely and securely for the safety all other residents. During a telephone interview on 10/25/24 at 1:52 PM, Licensed Practical Nurse #3 stated they worked full time and weren't aware of any residents that self-administered medications or kept medications at their bedside. Licensed Practical Nurse #3 stated for a resident to self-administer medications they would have to have an order. They stated the Medication Administration Record would indicate that the medication was kept at bedside and the nurses were responsible to follow up with the resident to ensure self-administration was completed. Licensed Practical Nurse #3 stated the check mark on the Medication Administration Record with the Nurses initials indicated the nurse administered that medication. Licensed Practical Nurse #3 stated they were familiar with Resident #78 and that Resident #78 might administer a nasal spray to themselves but that they had an order to do so. Licensed Practical Nurse #3 stated residents were not supposed to have their own medications at bedside. Use of all medication required a medical providers order because the residents were under the facility's care. Licensed Practical Nurse #3 stated that Unit C had wandering residents and medications should not be left out on a tray table for the safety of other residents on the unit. 10 NYCRR 415.3 (f)(1)(vi)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43785 Based on observation, interview, and record review conducted during a Complaint investigation (#NY00330826) during the Standard survey completed on 10/28/24, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming, personal and oral hygiene for four (Resident #19, #20, #41, and #88) of six residents reviewed. Specifically, Resident #20 was not provided with timely and complete incontinence care. Resident #41 was not provided with oral care. In addition, Residents #88 and #19 were not provided assistance with the removal of facial hair. The findings are, but not limited to: 1. Resident #20 had diagnoses including paraplegia (paralysis of lower extremities), spastic hemiplegia affecting left dominant side (muscles on one side of the body are in a constant state of contraction), and neuromuscular dysfunction of bladder (nerves and muscles that control bladder doesn't communicate properly with the brain). The Minimum Data Set (a resident assessment tool) dated 9/5/2024 documented Resident #20 was cognitively intact, was understood and understands. Resident #20 was incontinent of bowel and bladder and was dependent on staff for toileting hygiene. The comprehensive care plan dated 11/27/2016, documented Resident #20 had impaired skin integrity related to moisture and excoriation. The resident was incontinent and care was to be provided as needed. The Visual Bedside/Kardex (guide used by staff to provide care) documented Resident #20 required a total assist of 2 staff members for toileting tasks. Review of the Nursing Progress notes dated 9/1/24 to 10/23/24 revealed there was no documented evidence that Resident #20 refused incontinent care. During an interview on 10/24/24 at 9:49 AM, Resident #20 stated they had just been changed and gotten up for the day. During an interview on 10/24/2024 at 3:19 PM, Resident #20 stated they had asked Certified Nurse Aide #4 at 2:30 PM to be changed, but Certified Nurse Aide #4 stated they had to give a shower first. Resident #20 stated they had not been changed since they woke up at 9:30 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of incontinent care on 10/24/2024 at 4:38 PM, Certified Nurse Aides #4 and #1 transferred Resident #20 from the wheelchair into bed using a mechanical lift. There was a strong odor of urine noted as the resident was lifted out of the wheelchair. The lift sling and the resident's pants were visibly wet with urine. Certified Nurse Aides #1 and #4 washed their hands and put on gloves. Once Resident #20 was placed onto their bed their pants were removed. Certified Nurse Aide #1 exited the room to obtain a clean sling for Resident #20. Certified Nurse Aide #4 unfastened the tabs on Resident #20's incontinence brief; the brief was heavily saturated with urine and some feces. Certified Nurse's Aide #4 tucked the soiled brief in between Resident #20's legs while providing care and washed the abdominal folds and genitals from side to side without separating the skin folds. Certified Nurse Aide #4 then rolled Resident #20 on to their right side and tucked the soiled brief and soiled lift pad under the resident. Certified Nurse Aide #4 washed Resident #20's left and right buttocks, then went from front to back up the crease of the buttocks. Certified Nurse Aide #4's left gloved hand was visibly soiled with a small amount of brown stool. Certified Nurse Aide #4 (without changing their gloves) and Certified Nurse Aide #1 then placed a clean brief and dressed Resident #20. During an interview on 10/24/2024 at 5:04 PM, Certified Nurse Aide #4 stated they told Resident #20 they could not change them at 2:30 PM because they had to give a shower and wanted to get that over with first. During a follow up interview on 10/24/2024 at 5:34 PM, Certified Nurse Aide #4 stated they should have asked another staff member to change Resident #20 while they gave the shower and that it was not appropriate to leave a resident soaked in urine. During an interview on 10/24/2024 at 5:50 PM, Certified Nurse Aide #1 stated genital skin folds should have been washed and it was important to try to try and clean to the best of your ability to avoid cross contamination issues, especially if there was feces present. During an interview on 10/24/2024 at 5:59 PM, Registered Nurse Unit Manager #2 stated they expected staff to provide incontinent care before giving a shower. If they are unable to do so, then they should have asked other staff for assistance. During an interview on 10/25/2024 at 10:35 AM, Registered Nurse #3/Infection Preventionist stated the certified nurse aides should have cleansed the genital skin folds down the center and then down each side. During an interview on 10/25/2024 at 12:38 PM, the Director of Nursing stated all nurses and the unit manager on the floor were responsible for overseeing issues related to proper and timely incontinent care and hand hygiene. The policy and procedure titled Incontinent Care revised 3/22 documented wash the perineum (area between genitals and anus), anus, buttocks, abdomen, hips, and thighs. Clean the genital area from front to back. Clean the folds of the female genitals or the male genitals first. The policy and procedure titled Perineal Care revised 6/22 documented to provide sufficient access to the perineal area by gently flexing and spreading the resident's legs. Wash the perineal area from front to back to prevent contamination, use a clean section of wash cloth with each swipe and then use a second wash cloth to rinse area using the same technique of changing washcloth section and wiping front to back. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #41 diagnoses included progressive bulbar palsy (impairment of function of the cranial nerves), amyotrophic lateral sclerosis (nervous system disease) and dysarthria (slurred speech). The Minimum Data Set, dated dated dated [DATE] documented Resident #41 was cognitively intact was understood and understands. Resident #41 needed substantial/max assist with oral hygiene. The Comprehensive Care Plan dated of 1/18/24, documented Resident #41 had their own teeth and required maximum staff assist with oral care. During an interview and observation on 10/21/24 at 1:27 PM, Resident #41 stated the aides were supposed to brush their teeth, but they do not. Resident #41 stated they did not want to lose their teeth and have asked staff to brush them. Resident #41 was observed with their own teeth, some missing, and had a thick white buildup. Resident #41 stated their teeth felt like they needed to be brushed and had not been. During an observation on 10/23/24 at 12:18 PM, Resident #41 was seated in main dining room with buildup of white debris present on their front teeth. During a continuous observation on 10/24/24 from 8:17 AM to 8:49 AM, Resident #41 was provided morning care by Certified Nursing Assistants #5 and #6. Resident #41 was not offered or provided with oral care. During an interview on 10/24/24 at 9:05 AM, Certified Nursing Assistant #6 stated they were assigned to and completed morning care on Resident #41 today and on 10/23/24. Certified Nursing Assistant #6 stated oral care was typically done before bed at night. Certified Nursing Assistant #6 stated Resident #41 only gets oral care at night. Certified Nursing Assistant #6 stated they did not think Resident #41 had teeth, just gums. Certified Nursing Assistant #6 stated they should have asked Resident #41 if they wanted oral care and didn't. They stated oral care was important for hygiene, prevent infections and disease in residents' mouth. Having a clean mouth makes the residents feel better. Additionally, Certified Nursing Assistant #6 stated they didn't believe Resident #41 had a toothbrush. During an interview on 10/24/24 at 9:11 AM, Resident #41 stated they were not provided with oral care at bedtime and couldn't recall the last time their teeth were brushed. During an interview on 10/24/24 at 11:57 AM, Registered Nurse #1, Unit Manager, stated oral care was to be provided in the morning when a resident was gotten up and before bed. During an interview on 10/24/24 at 12:47 PM, Licensed Practical Nurse #4 stated Certified Nursing Assistants were responsible to perform oral care with AM (morning care) or after breakfast to remove bacteria that can cause gum disease or lead to heart disease. Licensed Practical Nurse #4 stated they do their best to ensure care was being provided. During an interview on 10/28/24 at 2:11 PM, the Director of Nursing stated oral care was to be completed twice a day and the nurses should be verifying that oral care was being provided by the Certified Nurse Aides. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy and procedure titled Oral Care effective 1/00 documented all residents receive appropriate oral care daily. The responsibility of everyone within the nursing department is to give good oral care for each resident. The policy and procedure titled AM (morning) and HS (night) Care revised 1/2024 documented all residents are provided with morning and night care daily. The procedure for morning care included to provide oral hygiene. 3. Resident #88 had diagnoses including dementia, depression, and anxiety. The Minimum Data Set, dated dated dated [DATE] documented Resident #88 had severe cognitive impairment and required moderate assistance with personal hygiene. There were no refusals of care documented in the Minimum Data Set. The comprehensive care plan dated 9/17/24 documented Resident #88 had a self-care performance deficit related to dementia with an intervention of moderate assistance for personal hygiene. The Visual/Bedside Kardex Report (a guide used by staff to provide care) dated 10/25/24 documented Resident #88 required moderate assist for personal hygiene and was to be offered choices related to care routine. Review of the Nursing Progress notes dated 10/1/24 to 10/25/24 revealed there was no documented evidence that Resident #88 refused to be shaved. During an observation on 10/22/24 at 8:30 AM, Resident #88 had long dark facial hair on their upper lip. During an observation on 10/24/24 at 3:38 PM, Resident #88 had long dark hairs on their upper lip approximately 0.75-1 inch in length. Additionally, Resident #88 had long grey hairs on their chin that were approximately one inch in length. During an interview on 10/25/24 at 9:37 AM, Certified Nurse Aide #2 stated Resident #88 was up early, so they completed their morning care while they were in the mood to have care completed. Certified Nurse Aide #2 stated as part of morning care, they washed Resident #88's arms, legs, perineal area, and face. They stated they put clean clothes on Resident #88 and then combed their hair. They stated that Resident #88's facial hair grows fast, but it looks like they have not had their hair removed for over a week. During an observation and interview on 10/25/24 at 9:43 AM, Certified Nurse Aide #1 stated Resident #88 had facial hair that should have been removed. During an interview on 10/25/24 at 12:17 PM, Licensed Practical Nurse #2 stated when Resident #88 refused care, staff could reapproach later or ask other staff for help. They stated the Certified Nurse Aides would tell them if Resident #88 refused care and they would usually document it in the electronic medical record in the progress notes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/24 at 12:22 PM, Registered Nurse Unit Manager #2 stated that Resident #88 could be difficult to provide care to at times, but they would expect the staff to reapproach and document when Resident #88 refused care. They expected staff to notify them whenever residents refused care. During an interview on 10/25/24 at 12:31 PM, the Director of Nursing stated they expected staff to provide facial hair removal as part of morning and nightly care, and at the very least on shower days, if the resident wanted it. The policy and procedure titled AM (morning) and HS (night) Care revised 1/2024 documented all residents are provided with morning and night care daily. The procedure for morning care included to provide assistance with shaving using disposable or electric razor. 10NYCRR 415.12(a)(3)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43785 Based on observation, interview, and record review conducted during Complaint investigations (#NY00337107) during the standard survey completed on 10/28/24, the facility did not ensure sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for one of one facility. Specifically, the facility did not meet their established minimum critical staffing numbers of staff for each shift. Additionally, there was a lack of sufficient nursing staff to provide timely care to meet the needs of the residents based on observation of residents not being assisted meals timely and interviews with residents, staff, resident council, and the ombudsman. This involves Residents #5, 11, 20, 31, 36, 40, 41, 45, 51, 58, 77, and 250. Refer to F677 Activities of Daily Living The findings are: The undated Comprehensive Emergency Management Plan documented if off-duty personnel are needed to support incident operations the senior most on-site facility official will confirm, with the administrator, the mobilization of off-duty personnel is permissible (ex: overtime pay). Once approved, department managers will be notified of the need to mobilize off-duty personal. The Emergency Plan documented that in accordance with employment contracts and collective bargaining agreements, an employee may be call upon to aide with work outside of job-prescribed duties, work in departments or carry out functions other than those normally assigned and work hours in hours more than their schedule. During the entrance conference on 10/21/24 at 10:01 AM, the Administrator stated the current facility census was 98 residents. 1. The Facility Assessment with initial assessment date 10/13/17, documented dynamic staffing patterns are utilized based on facility census and acuity levels. The Facility Assessment documented that the facilities critical staffing minimum numbers with a current census of 98 residents were to be a Registered Nurse Supervisor for each shift; three Licensed Practical Nurses for each shift; eight Certified Nurse Aides for the day and evening shift and three Certified Nurse Aides for the night shift. Review of an undated untitled document provided by the Director of Nursing on 10/23/24 documented the facilities census from 9/21/24-10/22/24 was between 95 and 102 residents. The daily staffing sheets, reviewed from 9/21/24 through 10/27/24, documented the facility did not meet their minimum number of staff on the following dates: 9/22/24 - down one 6:00 PM - 10:00 PM Licensed Practical Nurse; down one 2:00 PM - 10:00 PM Certified Nurse Aide; and one 6:00 PM - 10:00 PM Certified Nurse Aide 9/23/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/25/24 - down one 6:00 PM - 10:00 PM Licensed Practical Nurse and two 6:00 PM - 10:00 PM Certified Nurse Aides 9/26/24 - down one 6:00 PM - 10:00 PM Licensed Practical Nurse and three 6:00 PM-10:00 PM Certified Nurse Aides 9/27/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse 9/28/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse 9/29/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/3/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/4/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse and three 6:00 PM - 10:00 PM Certified Nurse Aides 10/5/24 - down one 2:00 PM - 10:00 PM Certified Nurse Aide and two 6:00 PM - 10:00 PM Certified Nurse Aides; and one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/6/24 - down two 2:00 PM - 10:00 PM Certified Nurse Aide; one 6:00 PM-10:00 PM Certified Nurse Aide; and one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/8/24 - down one 6:00 PM - 10:00 PM Certified Nurse Aide and one 10:00 PM-6:00 AM Licensed Practical Nurse 10/10/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/12/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse and one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/13/24 - down one 2:00 PM - 10:00 PM Certified Nurse Aide and one 2:00 PM - 6:00 PM Certified Nurse Aide 10/14/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse 10/19/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse; one 2:00 PM - 10:00 PM Certified Nurse Aide; and one 6:00 PM - 10:00 PM Certified Nurse Aide 10/20/24 - down one 2:00 PM - 10:00 PM Certified Nurse Aide and two 6:00 PM - 10:00 PM Certified Nurse Aides 10/21/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/22/24 - down one 2:00 PM - 10:00 PM Certified Nurse Aide 10/23/24 - down two 6:00 PM - 10:00 PM Certified Nurse Aides (continued on next page)

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	335683	A. Building B. Wing	10/28/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/25/24 - down one 2:00 PM - 6:00 PM Licensed Practical Nurse and one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/26/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse 10/27/24 - down one 10:00 PM - 6:00 AM Licensed Practical Nurse Review of the undated untitled document presented by the Director of Nursing on 10/24/24 documented that Unit A had 28 residents; Unit B had residents 38, and Unit C had 34. The resident acuity was as following: A Unit: Two residents that required maximum assist for feeding and one moderate assist for feeding; Eight residents that required two staff assist for transfers; one resident required two staff assist for toileting and two residents required two staff assist for bed mobility. B Unit: Two residents that were dependent on staff for feeing, two residents required maximum assist for feeding and two residents required moderate assist for feeding; Fifteen residents required two staff assist for transfers; Eleven residents required two staff assist for toileting; and nine residents who required two staff assist for bed mobility. C Unit: Two residents that were dependent on staff for feeing, two residents that required maximum assist for feeding and two residents that required moderate assist for feeding; Fifteen residents that required two staff assist transfers; Ten residents that required two staff assist for toileting; and four residents that required two staff assist for bed mobility. During an interview on 10/24/24 at 3:09 PM, the Staffing Coordinator stated the facilities critical staffing numbers for the 6:00 AM - 2:00 PM and the 2:00 PM - 10:00 PM shift were three nurses and eight Certified Nurse Aides. The 10:00 PM - 6:00 AM shift were three nurses and three Certified Nurse Aides. In addition, a Registered Nurse Supervisor was needed for all three shifts. The staffing coordinator stated they felt they were meeting minimal critical staffing numbers even when there was call-offs. 2. The Resident Council minutes for July 2024 documented call bells were taking a while to be answered. August 2024 minutes residents complained they weren't receiving showers and / or they were only receiving a shower once a week. September 2024 minutes residents complained call bells were not answered fast enough on the third shift, there were not enough staff on third shift and three resident's expressed showers were inconsistent. There were no facility responses documented. During Resident Council interviews on 10/22/24 from 11:03 AM to 11:37 AM, residents expressed they sometimes must wait a long time for their call bells to be answered. Residents expressed that this occurs across all shifts, they must wait to use the bathroom, or for their catheter bag to get emptied and must wait to receive something to drink. Residents expressed they were not receiving two showers a week when there were only two aides on a shift because the aides were too busy. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/22/24 at 1:50 PM, the Ombudsman stated residents complain about the lack of staffing and long wait times for call bells to be answered. They stated residents complain about sitting on the thrown for over 45 minutes. Additionally, they stated residents offer complaints about not receiving showers when they prefer, and food was delivered to units but sits there because there were not enough staff to serve the meals. 3. During an intermittent observation on 10/24/24 from 9:11 AM to 10:00 AM, Resident #58 and Resident #41 sat in Unit B lounge, with their breakfast trays covered in front of them waiting for staff assistance for eating. During an interview and observation on 10/24/24 at 9:56 AM, Licensed Practical Nurse #4 was at medication cart in the Unit B lounge with their back facing the residents. Licensed Practical Nurse #4 stated the Certified Nurse Aides were responsible to feed residents in the lounge. They stated the Certified Nurse Aides should initiate assisting residents with feeding right after the dietary caddie was passed. Licensed Practical Nurse #4 stated they oversee the Certified Nurse Aides and couldn't find anyone to feed the residents in the lounge. They stated there were only three Certified Nurse Aides scheduled on Unit B and one Certified Nurse Aide #5 was on break. Licensed Practical Nurse #4 stated they weren't assisting the residents with feeding because they were trying to get caught up with medication administration. They stated the residents should be receiving assist by now because it was 10:00 AM. During an interview on 10/24/24 at 11:13 AM, Certified Nurse Aide #5 stated they took their break instead of feeding dependent residents their breakfast because they thought the other staff were feeding them. Certified Nurse Aide #5 stated they did not realize the other staff were still providing care to residents. During an interview on 10/24/24 at 11:57 AM, Registered Nurse Unit Manager #1 stated any licensed or certified staff member were responsible for feeding residents. Registered Nurse Unit Manager #1 stated residents should be feed right when their food was received, so their food doesn't get cold and trays should not be left in front of residents with covers on them. Registered Nurse Unit Manager#1, stated they did not have adequate staffing on Unit B this morning. The nurses should have assisted with feeding and staff should not have taken any breaks until after the residents were assisted. Unit B after 8:30 AM had three Certified Nurse Aides; one aide on the unit was assigned to the main dining room, leaving only two aides on unit one of which was on a break. The residents don't get the time they deserve during care with the aides, corners are cut, residents might not get a full bed bath when they should, shaving and/or nail care isn't completed, and showers were not always given. 4. Interviews with residents revealed: During an interview on 10/21/24 at 11:14 AM, Resident #20 stated there were typically only two Certified Nurse Aides on the evening shifts and the weekend staffing was much worse. Resident #20 stated they prefer to be up before breakfast so that they could eat in the dining room, but there were many times when they were told they had to wait due to the number of staff on the floor and had to eat in their bed. During an interview on 10/21/24 at 11:34 AM, Resident #5 stated overnight shift staff were often upset due to lack of staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/21/2024 at 12:01 PM, Resident #51 stated they use their call light for staff assistance and have waited for up to 5 hours for staff to respond and it has been reported. During an interview on 10/21/24 at 1:37 PM, Resident #36 stated they were care planned to get up early, around 5:00 AM, and there was not enough staff to get them up that early. During an interview on 10/22/24 at 9:19 AM, Resident #250 stated the overnight shift does not have enough staff and there are times they wait for 45 minutes for their call bell to be answered. During an interview on 10/22/2024 10:07 AM, Resident #77 stated they were concerned with the lack of aides and nurses as they lay there wet all night and sometimes midday. They stated they used their call light and wait 1-3 hours for care to be provided. During an interview on 10/22/24 at 11:37 AM, Resident #45 stated they have had to wait 2 hours for requested pain medication and was not gotten out of bed when requested. They stated staff turn call bell off and state I'll be back, then they don't come back, and they must reactivate their call bell and wait again. During an interview on 10/22/24 at 1:46 PM, Resident #11 stated that all shifts were short staffed, and they wait a long time for their call bell to be answered. During an interview on 10/22/24 at 2:34 PM, Resident #40 stated they often wait 2 hours for their call light to be answered on the overnight shift and an hour on mornings and evening shifts. During an interview on 10/24/24 at 6:05 AM, Resident #31 stated they were care planned to get up anytime between 5:00 AM and 6:00 AM but there have been times they have had to wait until 10:00 AM due to short staffing. 5. During an interview on 10/24/24 at 5:44 AM, Certified Nurse Aide #10 stated they often work the night shift as the only aide along with one nurse. Certified Nurse Aide #10 stated the nurses were aware they were not providing resident care in accordance with their care plans and it's a safety concern. During an interview on 10/24/24 at 5:54 AM, Licensed Practical Nurse #5 stated Unit B was left alone a lot with just one aide on the 10:00 PM - 6:00 AM shift and the acuity of residents was too heavy to work with one aide. During an interview on 10/24/24 at 5:54 AM, Licensed Practical Nurse #1 stated when they were the only nurse working a unit, they must prioritize their treatments to get the worst ones completed. Licensed Practical Nurse #1 stated when there was only one aide on a unit, they would try to help the with the two-assist residents but at times the Certified Nurse Aide would do the resident by themselves. They stated the residents were not always getting their showers or incontinent care as they should. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/24/24 at 6:08 AM, Licensed Practical Nurse #9 stated they work the 6:00 PM through 6:00 AM shift and at times there was only one Certified Nurse Aide on the unit. When that happened, they needed to help the aides and that puts their medication pass late. Some residents were only getting incontinent care provided once a shift. Licensed Practical Nurse #9 stated that management was aware care was not being completed. During an interview on 10/24/25 at 6:14 AM, Registered Nurse #4 stated at times when they arrive to work at 10:00 PM there were still residents that needed to be put to bed. During a telephone interview on 10/24/24 at 6:57 AM, Certified Nurse Aide #11 stated they worked the night shift but at times started at 6:00 PM and usually worked with just another aide. They stated at times they cannot get the residents to bed per their preference, get them back out of bed if they ask, or give them their scheduled showers. During an interview on 10/24/24 at 5:34 PM, Certified Nurse Aide #4 stated there were normally only two Certified Nurse Aides working on the evening shift, and they work alone on the night shift with one nurse. Certified Nurse Aide #4 stated there were times that short staffing impacted the ability to give residents showers, provide necessary care in general, and to use mechanical lifts safely in accordance with facility policy. During a telephone interview on 10/25/24 at 3:57 PM, Certified Nurse Aide #10 stated when they come in for their scheduled night shift, many times they would punch in earlier to help the evening shift put residents to bed and many times those residents were saturated in urine. During a telephone interview on 10/28/24 at 10:45 PM, Registered Nurse Nursing Supervisor #5 stated to provide quality of care to the residents they would need to have two nurses and four Certified Nurse Aide per unit. Registered Nurse #5 stated they do not meet those staffing numbers. They stated that staff had to prioritize care needs over others and residents may need to be put to bed by the oncoming shift. During a telephone interview on 10/28/24 at 11:13 AM, Registered Nurse #6 stated they often had to supervise the building and work as a floor nurse. Registered Nurse #6 stated that the aides cannot get to the resident showers and only complete to one or two rounds of incontinent care. During an interview on 10/28/24 at 12:22 PM, the Director of Nursing after review of the actual staffing sheets from 9/22/24 -10/27/24 stated they were surprised their staffing numbers fell below the critical limit that often. The Director of Nursing stated at times they just worked below the critical staffing numbers. The Director of Nursing stated that they had given staff education on care plans and staff should be following the resident care plans. The Director of Nursing stated they felt their residents were safe and they were getting minimum quality of care but we could always do better. During an interview on 10/28/24 at 12:35 PM, the Administrator stated their staffing numbers have gotten better, and they do not intentionally staff the facility below their critical staffing numbers. The Administrator stated they were aware of the facility acuity. At times they allocated other staff and utilize ancillary staff. They stated they felt the residents were safe and felt they were getting quality of care and would always like to do more. (continued on next page)

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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** 43785 Based on observation, interview, and record review conducted during the Standard survey completed on [DATE], the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food safety for one (Main Kitchen) of one kitchen and two (Unit A and B) of two nourishment rooms. Specifically, the main kitchen had undated and/or unlabeled and unsealed food items. Additionally, the nourishment rooms had undated, unlabeled, and outdated food items and beverages. The findings are: The policy and procedure titled Food Receiving and Storage effective ,d+[DATE] documented potentially hazardous foods or time/temperature control for safety foods require time/temperature control for safety to limit the growth of pathogens or toxin formation. Raw animal foods will be separated and in drip proof containers during storage. All opened items will be labeled and dated and discarded after three days once opened. All non-potentially hazardous foods or time/temperature control for safety food items will be labeled and dated and discarded after five days once opened. The policy and procedure titled Food(s) Brought in From Outside the Facility effective ,d+[DATE] documented perishable foods must be labeled with resident's name and dated and consumed promptly. The facility is responsible for storing food brought in by family or visitors in a way that is separate from or easily distinguishable from facility food. All foods are labeled/dated and discarded after 3 days. During an observation on Unit B on [DATE] at 9:45 AM revealed the following items were in the Nourishment Room refrigerator: -a submarine sandwich in a restaurant bag undated with a resident's name -an undated plastic container of ham and lettuce with a resident's name -an undated plastic container of sliced cheese with a resident's name -an undated bag of sliced tomatoes with a resident's name on it -a cup of orange juice with no name or date -a slice of pie with a resident's name on it, dated ,d+[DATE] -two cups of banana pudding dated ,d+[DATE]. Continued observation revealed a sign on the refrigerator that documented, Refrigerators are for resident use only. Everything must be labeled and dated. Items without an expiration date must be thrown away after three days. Anything not labeled or dated will be thrown away. (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 at the time of the observation, Registered Nurse Unit Manager #1 stated the ham, lettuce, sliced cheese, and sliced tomatoes belonged to the same resident, as their family frequently brought in food. They stated they were not sure how long the sandwich had been in the refrigerator and the servings of banana pudding were not meant for one specific resident, but could be given to any resident, and were often used during medication administration. Registered Nurse Unit Manager #1 stated all foods in this refrigerator needed to be labeled with a name and a date and should only be kept for three days. During an observation of the Kitchen on [DATE] at 9:59 AM revealed the following items were in the walk-in refrigerator: -an opened package containing a large piece of ham, dated ,d+[DATE] -a tray containing approximately 20 small clear plastic cups of fruit cocktail, uncovered, unlabeled and undated. -a white plastic container labeled cottage cheese, approximately ,d+[DATE] empty. The expiration date was worn off the bottom and not legible, there was no best by or opened date visible. -a large food grade plastic container labeled sugar free vanilla pudding dated ,d+[DATE] -cut up onions, carrots, and another unidentifiable produce item cut up and wrapped in clear plastic wrap, unlabeled and undated During an interview at the time of the observation Assistant Food Service Director stated these items should all be labeled and dated when they were opened, and these items that were not properly labeled or dated should be thrown away and not used. Assistant Food Service Director stated, They could be contaminated or expired, and it is not safe to serve food like that. Food was good for 3 days from the date written on it, unless it has a best used by date that comes before those 3 days. During an observation on Unit A on [DATE] at 11:00 AM a black insulated lunch bag with containers of homemade foods was in the Nourishment Room refrigerator. The insulated bag and the food containers were not labeled with names and dates. During an interview at the time of the observation, Licensed Practical Nurse #1 stated they did not know who the insulated bag belonged to, it could belong to a staff member or could have been brought in by a resident's family, and the food items should be labeled with a name and date. During an interview on [DATE] at 12:43 PM, the Food Service Director stated the nighttime dietary supervisor was responsible for taking care of and throwing out leftover food items from the night before, and making sure food items that were not served were properly labeled and dated. The Food Service Director stated they were responsible for overseeing items were labeled and dated overall. The Food Service Director stated fruits and vegetables were good for 5 days and meats were good for 3 days after opening. If the item was not dated or labeled, then there was no way to know when it was opened or served so they would not serve it. Food Service Director stated there could be food borne illnesses. (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 1:07 PM, the Administrator stated it was expected that all food should be labelled and dated when it was opened and going into service because then they know it was good for consumption. They stated there was usually a sticker that was placed on the food container that states when it was put into the fridge and included a disposal date. The Administrator stated the fruit cocktail that was observed should not have been left uncovered. Ultimately the Food Service Director was responsible to ensure all food in fridges, in the kitchen and on the units, were labelled and dated appropriately. 10 NYCRR 415.149(h) Subpart ,d+[DATE] ,d+[DATE].40 ,d+[DATE].43

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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. 43785 Based on observation, interview, and record review conducted during the Standard survey completed on 10/28/2024, the facility did not maintain an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for one (Resident #20) of two resident reviewed. Specifically, staff did not change their gloves or perform hand hygiene when visible feces was observed on their glove during incontinent care, and touched items in the environment including the mechanical lift, tray table, and door handles. The finding is: The policy and procedure titled Policy on Hand Washing effective revised 11/19 documented all personnel working in the long-term care facility are required to wash their hands in the following situations, but is not limited to: when hands are visibly soiled, before and after direct resident contact for which hand hygiene is indicated by acceptable professional practice, before and after assisting a resident with toileting, and after contact with a resident's mucous membranes and body fluids or excretions. The policy and procedure titled Infection Prevention and Control revised 6/24 documented the facility must establish an infection prevention and control program that must follow accepted national standards that include a system for preventing infections under arrangements based upon the facility's assessment. Resident #20 had diagnoses including paraplegia (paralysis of lower extremities), spastic hemiplegia affecting left dominant side (muscles on one side of the body are in a constant state of contraction), and neuromuscular dysfunction of bladder (nerves and muscles that control the bladder don't communicate properly with the brain). The Minimum Data Set (a resident assessment tool) dated 9/5/24 documented Resident #20 was cognitively intact, was understood and understands. Resident #20 was incontinent of bowel and bladder and was dependent on staff for toileting hygiene. Review of the comprehensive care plan revised 5/3/23, documented Resident #20 had impaired skin integrity related to moisture and left gluteal fold excoriation. Skin will remain free from skin breakdown/further breakdown through next review. Interventions included skin and feet check with daily care. The comprehensive care plan documented an alteration in bladder function related to incontinence secondary to paraplegia. Interventions included incontinent care as needed. The Visual/Bedside Kardex (guide used by staff to provide care) dated 10/25/24 documented Resident #20 required a total of 2 staff assist for toileting tasks. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of incontinent care on 10/24/2024 at 4:38 PM, Certified Nurse Aides #4 and #1 transferred Resident #20 from the wheelchair into bed using a mechanical lift. There was a strong odor of urine noted as the resident was lifted out of the wheelchair. The lift sling and the resident's pants were visibly wet with urine. Certified Nurse Aides #1 and #4 washed their hands and put on gloves. Once Resident #20 was placed onto their bed their pants were removed. Certified Nurse Aide #4 unfastened the tabs on Resident #20's incontinence brief; the brief was heavily saturated with urine and some feces. Certified Nurse's Aide #4 tucked the soiled brief in between Resident #20's legs while providing care and washed the abdominal folds and genitals. Certified Nurse Aide #4 washed Resident #20's left and right buttocks, then went from front to back up the crease of the buttocks. Certified Nurse Aide #4's left gloved hand was visibly soiled with a small amount of brown feces. Certified Nurse Aide #4 (without changing their gloves) and Certified Nurse Aide #1 then placed a clean brief and dressed Resident #20. Without changing/removing gloves or completing hand hygiene the certified nurse aides transferred the resident back into their wheelchair using the mechanical lift touching the lift and the controller. Certified Nurse Aide #4 without changing their soiled gloves or completing hand hygiene then moved a tray table, emptied the basin of soiled water into the toilet, and placed it in the bedside table. Certified Nurse Aide #4 while still wearing the same gloves (donned at the start of care) gathered the soiled linens and garbage, opened the door, walked across the hall opened the door to the soiled work room, and discarded the items. Certified Nurse Aide #4 then removed their soiled gloves and completed hand hygiene in the work room. During an interview on 10/24/24 at 5:04 PM, Certified Nurse Aide #4 stated they should have changed their gloves after providing incontinent care to Resident #20 because that was cross contamination. Certified Nurse Aide #4 stated they did not notice the feces on their gloves until they removed them in the soiled work room to perform hand hygiene. Certified Nurse Aide #4 stated they should not have touched anything in the room after providing incontinent care with feces present and before performing hand hygiene. During an interview on 10/24/24 at 5:59 PM, Registered Nurse Unit Manager #2 stated gloves should be changed and hand hygiene should be performed whenever the gloves were soiled to avoid cross contamination and infections. During an interview on 10/25/24 at 10:35 AM, Registered Nurse #3/ Infection Preventionist stated hand hygiene and glove changes should be performed whenever gloves were visibly soiled during incontinent care to prevent cross contamination. During an interview on 10/25/24 at 12:38 PM, the Director of Nursing stated they expected hand hygiene to be completed before and after all care, and especially when the gloves were soiled. That was an infection control issue and could cause cross contamination. The Director of Nursing stated all nurses and the unit manager on the floor were responsible for overseeing issues related to hand hygiene. 10NYCRR 415.19(b)(4)