STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335704	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnsville Rehabilitation and Nursing Center	7 Timmerman Avenue Saint Johnsville, NY 13452

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews conducted during the recertification survey, the facility did not ensure each resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life for two (2) (Resident #s 11 and 86) of 24 residents reviewed. Specifically, (a.) Resident #11 foley's catheter bag was exposed; (b.) Resident #86 heard Certified Nurse Aide #1 and Certified Nurse Aide #2 stated they had to wait and be the last one for care because they were so slow. Certified Nurse Aide #2 when asked to remove a raised toilet seat before Resident #86 used the bathroom, they replied, ?no, I am not breaking my back.' Resident #86 stated in both instances they were offended. This is evidenced by:The facility's Policy and Procedure titled, Resident Rights, revised 04/15/2025, documented residents at the facility, in accordance with Federal regulation (42 Code of Federal Regulation 483.13) and New York State Title 10 Health Code will be provided care that is dignified and in accordance with the Residents Rights. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.Residents have the right to be treated with dignity, respect and consideration at all times. Privacy in the treatment and care of your personal needs. Staff should interact with the resident in ways that maintain and enhance their self-esteem and self-worth. Respecting residents by speaking respectfully focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care; refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a resident's request for toileting assistance.Resident #11Resident #11 was admitted to the facility with diagnoses of disease of the digestive tract, obstructive uropathy (a condition where the flow of urine is blocked, leading to the accumulation of urine in the urinary tract), and Alcoholic Cirrhosis (a late-stage, severe liver disease caused by heavy, prolonged alcohol use, where healthy liver tissue is replaced by permanent scar tissue). The Minimum Data Set (an assessment tool) dated 07/25/2025 documented the resident's cognition was intact, able to be understood and be understand others.During an observation on 08/25/2025 at 12:32 PM, Resident #11 came out of their room for lunch. Urinary catheter bag underneath wheelchair was not concealed in a dignity bag, and at times dragged on the floor.During an observation 08/25/2025 at 12:32 PM, Resident #11 came out of an Activity Room with their urinary catheter bag underneath their wheelchair; The catheter bag was not concealed in a dignity bag and at times dragged on the floor.During an interview on 08/28/2025 at 11:35 AM, Certified Nurse Aide #3 stated the catheter bag should have been in another bag and not dragging on the floor. They stated that they were unaware the catheter bag was not concealed and would immediately place the bag in a dignity bag. Certified Nurse Aide #3 also stated Resident #11 at times removed the catheter bag from the dignity bag leaving it exposed.During an interview on 08/29/2025 at 10:45 AM, Licensed Practical Nurse #2 stated the Certified Nurse Aides got residents up and dressed for the day and was not always sure if they placed catheter bag in a dignity bag. Licensed Practical Nurse #2 stated catheter bags should always be concealed for dignity, and if they noted bag was exposed, they would (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	immediately place the catheter bag in a dignity bag. Resident #86Resident #86 was admitted to the facility with diagnoses of acute kidney failure (a condition where the kidneys suddenly lose their ability to function properly), heart failure (a condition where the heart cannot pump blood effectively enough to meet the body's needs), and chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing airflow obstruction and breathing problems). The Minimum Data Set, dated [DATE] documented the resident's cognition was intact, could be understood and be understand others.The Comprehensive Care Plan titled; Activities of Daily Living, dated 4/18/2024, documented Resident #86 required assistance with Activities of Daily Living functions related to obesity, lymphedema, failure to thrive, and weakness. Interventions included: Dressing- Footwear: Substantial/maximal assistance Dressing: Lower Body: Substantial/maximal assistance Lying to Sitting: Partial/Moderate assistance; Toilet Hygiene: Dependent.During an interview on 08/26/2025 at 10:12 AM, Resident #86 stated on Saturday, 8/23/2025, they had their light on at 3:00 PM, and no one came to help until 9:00 PM. They stated their roommate was helped between 3:00 PM and 9:00 PM. Resident #86 stated Certified Nurse Aide #1 came in at 8:00 PM and told Certified Nurse Aide #2 that the reason they had left Resident #86 for last was because they took too long. They stated Certified Nurse Aide #1 told Certified Nurse Aide #2 the resident sat in the bathroom for 45 minutes. Resident #86 stated they could not control the amount of time they took in the bathroom. Resident #86 stated when they stood up at 9:00 PM, they lost their water (urinated down their legs). Resident #86 stated when they put their light on, the aide was supposed to help them to the bathroom. Resident #86 stated their roommate's commode was over the toilet seat and they told Certified Nurse Aide #2 that they did not use that. Certified Nurse Aide #2 then told the resident, Well, I'm not breaking my back to move it. Resident #86 stated they pulled the commode off the toilet themselves so they could use the toilet. Resident #86 stated Certified Nurse Aide #2 did help them get to bed after that but did not wash them up. Resident #86 stated they were so disgusted with the aide, they did not want to ask them for anything else. Resident stated Certified Nurse Aide #2 did not clean up the puddle of urine that was on the floor. They stated they usually had to wait to go to the bathroom between supper and bedtime.During an interview on 08/29/2025 at 11:30 AM, Director of Nursing #1 stated they interviewed Certified Nurse aide #1, who admitted they made the statement to save Resident #86 for last because they were so slow, but there was no malintent. They were educated about speaking where they could be overhead about residents.During an interview on 08/29/2025 at 1:52 PM, Certified Nurse Aide #1 stated they remember giving report to oncoming Certified Nurse Aide #2. They told Certified Nurse Aide #2 to provide care to Resident #86 last due to the amount of time it took to complete their care as Resident #86 was very particular. Certified Nurse Aide #1 then attempted to recant their statement stating it was not them who made the statement. During an interview on 09/03/2025 at 11:10 AM, Administrator #1 stated all staff were expected to treat all residents with dignity and respect. During 2024 the facility used agency staff often. They have hired several new nursing employees and down to only a few open positions left.10 New York Code of Rules and Regulations 415.5(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review and staff interviews conducted during the recertification survey, the facility did not ensure that it maintained acceptable parameters of nutritional status, provided nutrition care and services to each resident consistent with the resident's comprehensive assessment for three (3) (Resident #s 6, 48, and 107) of seven (7) residents reviewed for nutrition/hydration status maintenance. Specifically, (a.) Resident #6 had a documented weight loss of 17.7 pounds in a month, (b) Resident #48 had a documented weight gain of 22.5 pounds in a month, and (c) Resident #107 had a documented weight loss of 35.6 pounds. The significant weight changes were not confirmed by reweights or addressed by the facility's dietician or medical providers.This is evidenced by:The facility's Policy and Procedure titled, Weighing of a Resident, last revised 8/10/2015, documented a difference of plus or minus five (5) pounds from the previously recorded weight required a reweigh that same day with the assistance of the charge nurse or nurse manager. The charge nurse or nurse manager would be responsible to ensure that weights are completed as ordered. The charge nurse or nurse manager would verify a weight of plus or minus five (5) pounds. Additionally, they would report any five (5) pound weight change to the Dietician. The medical staff and dietician will review weights.Resident #6:Resident #6 was admitted to the facility with diagnoses of paraplegia (paralysis that mainly affects the legs), dysphagia (difficulty swallowing), and acute kidney failure. The Minimum Data Set (an assessment tool) dated 8/1/2025 documented the resident had moderate cognitive impairment, could sometimes understand others, and could make themselves understood.A Comprehensive Care Plan titled, Potential Nutritional Problem, last revised on 08/27/2025, documented a goal for maintaining adequate nutritional status as evidenced by maintaining stable weight.The resident's weights and Vitals Summary documented the resident weighed 212.7 pounds on 07/08/2025 and weighed 195 pounds on 8/17/2025, representing a loss of 17.7 pounds.A review of the resident's medical record revealed no documented evidence of a re-weight, nutrition assessment, medical provider, or dietician notes addressing the weight loss.During an interview on 09/02/2025 at 12:20 PM, Licensed Practical Nurse #1 stated the nurses usually entered weights in the electronic medical record and that residents should be weighed when they were admitted or readmitted . Licensed Practical Nurse #1 stated they did not know why the resident's weight was not done for almost three (3) weeks after readmission.During an interview on 09/03/2025 at 9:30 AM, Registered Dietitian #1 stated a weight should have been done on readmission, not almost three (3) weeks after readmission. They stated the resident was being discussed in weight meeting that day (09/03/2025).Resident #48Resident #48 was admitted to the facility with diagnoses of diabetes, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and dementia. The Minimum Data Set (an assessment tool) dated 7/21/2025 documented the resident had intact cognition, could understand others, and could make themselves understood.A Comprehensive Care Plan titled, Potential Nutritional Problem, last revised on 06/11/2025, documented a goal of stabilized weight.The resident's weights and Vitals Summary documented on 7/08/2025 the resident weighed 134.7 pounds and on 8/19/2025 the resident weighed 157.2 pounds, representing a weight gain of 22.5 pounds.A review of the resident's medical record did not have documented evidence of a re-weight, nutrition assessment, medical provider, or dietician notes addressing the weight gain.During an interview on 9/03/2025 at 9:30 AM, Registered Dietitian #1 stated they felt it was an error, but the resident was sent to the hospital (on 8/26/2025) before a reweight could be obtained. They stated staff were not consistent with entering weights into the electronic medical record.Resident #107: Resident #107 was admitted to the facility with diagnoses of quadriplegia (paralysis of all four limbs), diabetes, and pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and the right side of the heart). The Minimum Data Set (an assessment tool) dated 8/01/2025 documented the resident had moderate cognitive impairment, could sometimes understand others, and could make themselves understood.A Comprehensive Care (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan titled; Nutritional Risk, last revised on 06/17/2024 documented a goal to promote nutritional intake necessary to maintain or improve current weight.The resident's weights and Vitals Summary documented on 7/08/2025 the resident weighed 239 pounds and on 08/19/2025 the resident weighed 203.4 pounds, representing a 35.6-pound loss.A review of the resident's medical record did not have documented evidence of a re-weight, nutrition assessment, medical provider, or dietician notes addressing the weight loss.During an interview on 09/03/2025 at 9:30 AM, Registered Dietitian #1 stated they asked for a reweigh for this resident and have not gotten it. They stated they did not believe the weight was accurate. They stated they sent an email to Director of Nursing #1, Unit Manager and Food Service Director when asking for a reweight.During an interview on 09/03/2025 at 10:31 AM, Director of Nursing #1 stated they had spoken to the unit managers about weights and reweights. They report the reweights were being done but were not being put in the computer so Dietitian #1 could see them.During an interview on 9/03/2025 at 12:35 PM, Registered Nurse #1 stated they would receive an email from Dietitian #1, print out a list of residents who need weights and tell the nurses and Aides. They stated all residents should be weighed the day they are admitted . They further stated that Certified Nurse Aides would write the weights down and nurses would enter them into the computer. 10 New York Code Rules and Regulations 415.12(c)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a recertification and abbreviated survey (Case # 2562681), the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, residents reported that staff would not be able to provide them care for extended periods of time. Review of the actual staffing schedule revealed that on multiple occasions from 08/11/2025 to 09/01/2025, the facility staffing levels were below the facility assessment. This is evidenced by: The Facility Assessment, last reviewed in July 2025, documented that the facility's bed capacity was 120. The section titled, Staffing Plan, documented the following staffing needs based on a full facility census per day: 18.40 Licensed Nurses and 28.67 Certified Nursing Assistants.Upon entrance to the facility on [DATE], 116 residents resided on three (3) units. Upon observation and review of the Facility Staffing Sheet, five (5) Licensed Nurses and eleven Certified Nurse Aides were on duty.During a surveyor-led group resident meeting on 08/26/2025 at 10:00 AM, six (6) residents who attended the meeting reported insufficient staffing to meet their needs. They stated that they often had to wait an extended period to get care. They stated that many times they have been left unattended for extremely long times, and the Certified Nurse Aides would say they would come back but never did. A review of staffing sheets provided by the facility from 08/11/2025 through 09/01/2025 documented that they did not meet their assessed minimum staffing on most shifts for the following:- On 08/11/2025, the nursing schedule had 6 nursing staff during the day shift, 5 for the evening shift, and 4 for the night shift for a total of 15. The Certified Nurse Aide schedule had 12 aides during the day shift, 10 for the evening shift, and 6 for the night shift for a total of 28. - On 08/14/2025, the nursing schedule had 6 nursing staff during the day shift, 5 for the evening shift, and 4 for the night shift for a total of 15. The Certified Nurse Aide schedule had 12 aides during the day shift, 9 for the evening shift, and 6 for the night shift for a total of 27. - On 08/17/2025, the nursing schedule had 4 nursing staff during the day shift, 4 for the evening shift, and 4 for the night shift for a total of 12. The Certified Nurse Aide schedule had 12 aides during the day shift, 9 for the evening shift, and 5 for the night shift for a total of 26. - On 08/20/2025, the nursing schedule had 5 nursing staff during the day shift, 5 for the evening shift, and 3 for the night shift for a total of 13. The Certified Nurse Aide schedule had 12 aides during the day shift, 9 for the evening shift, and 4 for the night shift for a total of 25. - On 08/23/2025, the nursing schedule had 4 nursing staff during the day shift, 4 for the evening shift, and 4 for the night shift for a total of 12. The Certified Nurse Aide schedule had 12 aides during the day shift, 9 for the evening shift, and 4 for the night shift for a total of 25. - On 08/25/2025, the nursing schedule had 7 nursing staff during the day shift, 7 for the evening shift, and 4 for the night shift for a total of 18. The Certified Nurse Aide schedule had 11 aides during the day shift, 10 for the evening shift, and 4 for the night shift for a total of 25. - On 08/28/2025, the nursing schedule had 7 nursing staff during the day shift, 4 for the evening shift, and 3 for the night shift for a total of 14. The Certified Nurse Aide schedule had 11 aides during the day shift, 10 for the evening shift, and 8 for the night shift for a total of 29. - On 09/01/2025, the nursing schedule had 4 nursing staff during the day shift, 4 for the evening shift, and 3 for the night shift for a total of 11. The Certified Nurse Aide schedule had 9 aides during the day shift, 11for the evening shift, and 4 for the night shift for a total of 24. During an interview on 08/27/2025 at 1:08 PM, Certified Nursing Aide #1 stated that staff were able to provide care consistently; however, the residents did have to wait for a more extended period at times.During an interview on 8/29/2025 at 1:00 PM, Administrator #1 stated that the facility assessment was based on the full capacity of the facility. They stated that at times they did not meet the assessment, but they were trying to get to that point. During an interview on 09/03/2025 at 10:30 AM, Staffing Coordinator #1 stated they (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determined the staffing levels per the census; it was discussed at the morning meeting what the goal for the staffing levels should be for the next day. They stated that the goal was to have a minimum of four (4) Certified Nurse Aides on each unit during the day, three (3) Certified Nurse Aides on each unit during the evening, and one (1) Certified Nurse Aide on each unit during the overnight. They stated that if they were short-staffed, they would attempt to fill the spots by offering bonuses or other incentives to get staffing at appropriate levels. They stated that they were short at times but were getting better. They stated that the Director of Nursing was bringing staff in from other areas to increase their staffing levels. They stated that they did have a nurse training program and were getting more staff from that program. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interview conducted during the recertification survey, it was determined that the facility did not post nurse staffing information in an area accessible to all residents and visitors, as required by the posting requirements. Specifically, the posting of daily nurse staffing levels for staff working in the facility on each shift from 08/25/2025 through 09/03/2025 was located at the far end of the building. This is evidenced by: During observations from 8/25/2025 through 9/03/2025, the daily nurse staffing postings were located in a hallway at the far end of the building near the human resources office, which was not readily visible or accessible to all residents and visitors. Visitors of the B and C units would have to walk to the opposite end of the building to view the daily staffing, while visitors of the A unit were able to view when walking byDuring an interview on 9/03/2025 at 11:15 AM, Staffing Coordinator #1 stated that ever since they have worked at the facility, the daily staffing had always been posted in that location. They stated that the night nursing supervisor would post the daily staffing list. They stated that they did not know that the staffing had to be posted in a different location and mentioned that they would move it to the front reception area if needed. 10 New York Codes, Rules, and Regulations 415.13

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed five (5) percent for two (2) (Resident #s and 46) of two (2) residents observed during medication administration with 25 observations. This resulted in a medication error rate of 88 percent.This is evidenced by:The facility ' s Policy and Procedure titled, Medication Nurse Routine. Revised: 12/19/2024, documented all Medication Nurse duties are performed by licensed personnel. Procedures will be performed as follows by all staff uniformly. During the medication pass read orders from electronic medical record, Compare prescription label on blister pack to medication order. Remember the five (5) rights: a) right medication b) right resident c) right time d) right dose e) right route. Also check expiration dates. Crushing medications - crush only those meds which are not on the do not crush list. i) Special considerations should be noted on the electronic medical record, (crush, takes whole in applesauce, alternate days, etcetera). The nurse is to verify the medication administration record and treatment administration record at the beginning, during, at the end of their assigned shift to ensure timely administration of medications and treatments.Resident #8Resident #8 was admitted to the facility with diagnoses of fractured femur and fractured humerus (broken hip and broken arm), chronic obstructive pulmonary Disease (a group of lung diseases that cause ongoing inflammation and damage to the airways and lungs, leading to breathing difficulties), and diabetes type 2 (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin). The Minimum Data Set (an assessment tool) dated 07/22/2025 documented the resident's cognition was intact, could be understood and understand others.The Comprehensive Care Plan dated 07/08/2025 documented Resident #8 had hypertension, hyperlipidemia (elevated levels of lipids (fats) in the bloodstream) and history of bradycardia (an abnormally slow heart rate). Interventions include give medications as ordered. Observe for side effects such and effectiveness. Resident #8 had diabetes mellitus. Intervention give Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.The Medication Administration Record dated August 2025 for Resident #8 documented Resident took medication whole. The following medications were to be administered at 8:00 AM:Diltiazem Extended Release 24 Hour 120 milligrams. Give 1 capsule by mouth in the morning for hypertension.Ezetimibe Oral Tablet 10 milligram. Give 1 tablet by mouth in the morning for hyperlipidemia.Fluticasone Propionate Nasal Suspension 50 micrograms (delivered per actuation or puff). 1 spray in both nostrilsLactobacillus Rhamnosus Oral Capsule. Give 1 capsule by mouth in the morning for probiotic.Losartan Potassium Oral Tablet 25 milligram tablet. Give 12.5 milligrams by mouth in the morning for hypertension.Meloxicam Oral Tablet 15 milligrams Give 1 tablet by mouth in the morning for arthritis pain.Montelukast Sodium Oral Tablet 10 milligrams. Give 1 tablet by mouth in the morning for allergies.oxybutynin Chloride Oral Tablet Extended Release 24 Hour 15 milligrams. Give 1 tablet by mouth in the morning for bladder spasms.Pantoprazole Sodium Oral Tablet Delayed Release 40 milligrams. Give 1 tablet by mouth in the morning for gastroesophageal reflux.Keflex Oral Capsule (Cephalexin) Give 500 milligrams by mouth three times a day for preventative for 7 Days effective 8/26/2025Aspirin Oral Capsule 81 milligrams. Give 1 capsule by mouth every morning and at bedtime for preventative.During an observation on 08/28/2025 at 9:07 AM, License Practical Nurse #2 crushed and administered the following medications to Resident #8: Diltiazem tablet Extended Release 24 Hour 120 milligrams; Keflex capsule 500 milligrams; Magnesium Oxide tablet 400 milligrams; Meloxicam tablet 15 milligram; Montelukast Sodium Oral tablet 10 milligrams; Losartan Potassium tablet 25 milligrams; Lactobacillus Rhamnosus 1 capsule; Tramadol tablet 25 milligrams; Pantoprazole Sodium Oral tablet Delayed Release 40 milligrams; oxybutynin extended release tablet 15 milligrams; Ezetimibe tablet 10 milligrams; Aspirin 81 milligrams capsule. The following medications were labeled Do Not Crush: Diltiazem, Magnesium Oxide, Montelukast Sodium, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pantoprazole Sodium Oral Tablet Delayed Release, oxybutynin extended release, and Ezetimibe tablet. Resident #8's Medication Administration Record documented medications taken whole.During an interview on 08/28/2025 at 9:25 AM, License Practical Nurse #2 stated they crushed Resident #8's medication because they took them better that way. Licensed Practical Nurse #2 was unable to provide a physician's order to crush medications for this resident. Licensed Practical Nurse #2 stated they were unaware that the above listed medications were not to be crushed. They stated they would notify the Director of Nursing.Resident #46Resident #46 was admitted to the facility with diagnoses of osteoarthritis (a common, degenerative joint disease that occurs when the cartilage that cushions the ends of bones wears down over time); hypertension (a condition where the force of blood against the walls of the arteries is consistently above normal levels, and anxiety (a common mental health condition characterized by excessive and persistent worry, fear, and unease). The Minimum Data Set, dated [DATE] documented the resident's cognition was moderately impaired, could be understood and understand others.The Comprehensive Care Plan dated 4/10/2024, documented Resident #46 is on multiple medications. Intervention: Perform a medication reconciliation report with resident and or family members/responsible party.The Medication Administration Record dated August 2025 for Resident #46 documented the following medications were to be administered at 8:00 AM:Cranberry Oral Capsule. Give 1 capsule by mouth in the morning for supplement.Norvasc Oral Tablet 10 milligrams (Amlodipine Besylate). Give 1 tablet by mouth in the morning for hypertension.Pantoprazole Sodium Oral Tablet Delayed Release 40 milligrams. Give 1 tablet by mouth in the morning for gastroesophageal reflux disease.Pepcid Oral Tablet 40 MG (Famotidine). Give 1 tablet by mouth in the morning for gastroesophageal reflux disease.Metoprolol Succinate Oral Tablet Extended Release 24 Hour 100 milligrams. Give 1 tablet by mouth in the morning for hypertension, give with 25 milligrams for total of 125 milligrams.Metoprolol Succinate Oral Tablet Extended Release 24 Hour 25 milligrams. Give 1 tablet by mouth in the morning for hypertension give with 100 milligrams for total of 125 milligrams.Senna Oral Tablet 8.6 milligrams (Sennosides) Give 2 tablet by mouth in the morning for constipation.PreserVision Oral Capsule Give 1 capsule by mouth two times a day for supplement.Tylenol Extra Strength Oral Tablet 500 milligrams (Acetaminophen). Give 2 tablets by mouth two times a day for pain.Isradipine Oral Capsule 5 milligrams. Give 1 capsule by mouth two times a day for hypertension.During an observation on 08/28/2025 at 10:15 AM, Licensed Practical Nurse #3 poured 8:00 AM medications for Resident #46. They poured medications into two separate cups; one cup was for crushed medications and the other cup was for do not crush medications. Licensed Practical Nurse #3 poured Metoprolol Succinate ER 100 milligrams into the do not crush cup. They were prompted that they poured metoprolol extended release, a do not crush medication into the crush medication cup. In an interview, Licensed Practical Nurse #3 stated they were unaware that Metoprolol extended-release drug should not be crushed. They had been crushing the medication up until this time. They notified Registered Nurse #1. Registered Nurse #1 reviewed order and medication blister package and informed Licensed Practical Nurse #3 that they should not crush metoprolol extended release. They stated they would notify the nurse practitioner for an order change.During an interview on 08/28/2025 at 9:50 AM, Licensed Practical Nurse #3 stated they had not completed 8:00 AM medication pass for Resident #46 because they were waiting for them to get dressed and out of bed. Licensed Practical Nurse #3 stated to avoid choking or aspiration they wait until residents were out of bed before administering medication. They also stated they were the only nurse passing medications on floor for 40 residents. They stated the assisting Registered Nurse Manager #1 was aware.During an interview on 08/28/2025 at 10:30 AM, Registered Nurse #1 stated they had not been informed that the 8:00 AM medications were late, and Licensed Practical Nurse #3 did not ask for help. They stated they would assist Licensed Practical Nurse #3 in completing the medication pass and get residents dressed and out of bed. During an interview on 08/28/2025 at 10:45 AM, Nurse Practitioner #1 stated they had not been notified that medications were late today or any other day in the past. They stated medication nursing staff should notify nurse practitioner or physician when (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were given late, and, that an order was required for nurse to crush medications. They stated if a resident was unable to take medications whole and medications that specifically were not to be crushed would not be ordered for that resident. An alternative medication would be prescribed, if not available in a liquid form. Nurse Practitioner stated the Minimum Data Set Coordinator was currently conducting an audit on all mediations that were not crushable. They stated Medication Administration Record would be updated if needed.During an interview on 08/28/2025 at 11:00 AM, Director of Nursing #1 stated currently they did not have a nurse educator. Director of Nursing #1 stated all nurses received medication administration training upon hire which included a preceptorship, observation and competency signoff. A medication error report will be completed for Licensed Practical Nurse #2's medication error reported today. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, record review and interview conducted during the recertification survey, the facility did not ensure residents were free from significant medication errors for one (1) (Resident #8) of two (2) residents reviewed during a medication administration observation. Specifically, Licensed Practical Nurse #2 crushed and administered medications that were Do Not Crush for Resident #8.This is evidenced by:The facility's Policy and Procedure titled, Medication Nurse Routine, last revised 12/19/2024, documented all Medication Nurse duties are performed by licensed personnel. Procedures will be performed as follows by all staff uniformly. During the medication pass read orders from electronic medical record, compare prescription label on blister pack to medication order. Remember the five (5) rights: (a) right medication (b) right resident (c) right time (d) right dose (e) right route. Please check expiration dates. Crushing medications - crush only those medications that are not on the Do Not Crush List. i) Special considerations should be noted on the electronic medical record, (crush, takes whole in applesauce, alternate days, etc). The nurse is to verify the medication administration record and treatment administration record at the beginning, during, at the end of their assigned shift to ensure timely administration of medications and treatments.A government National Institute of Health study dated 02/2024, documented, Diltiazem Hydrochloride Extended-Release Capsules should be taken on an empty stomach. Patients should be cautioned that the Diltiazem hydrochloride extended-release capsules should not be opened, chewed or crushed, and should be swallowed whole.Extended-Release Diltiazem should never be crushed or chewed, according to manufacturers and health organizations including the Food and Drug Administration, Kaiser Permanente, and the Cleveland Clinic. Crushing the medication would destroy its special coating, causing the entire dose to be released at once. This could lead to a dangerous overdose and serious heart-related side effects.Reference made to https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=70293a05-d314-43fa-a2b1-398cfb39edf8Res #8 was admitted to the facility with diagnoses of fractured femur and fractured humerus (broken hip and broken arm), chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and damage to the airways and lungs, leading to breathing difficulties), and Type Two (2) Diabetes (a chronic condition in which the body does not use insulin effectively or does not produce enough insulin to keep blood sugar levels within a healthy range). The Minimum Data Set (an assessment tool) dated 07/22/2025, documented the resident's cognition was intact, could be understood and understand others.The Comprehensive Care Plan dated 07/08/2025 documented Resident #8 had hypertension (high blood pressure), hyperlipidemia (elevated levels of fats in the bloodstream) and history of bradycardia (an abnormally slow heart rate). Interventions included to give medications as ordered and observe for side effects and effectiveness.During an observation on 08/28/2025 at 9:07 AM, License Practical Nurse #2 crushed and administered the following medications documented on the medication administration record for Resident #8: Diltiazem tablet extended Release 24 Hour 120 milligrams; Keflex capsule 500 milligrams; oxybutynin extended-release tablet 15 milligrams; Tramadol 50 milligrams, and Pantoprazole Sodium Oral Tablet Delayed Release. These medications were labeled as Do Not Crush. During an interview on 8/28/2025 at 9:25 AM, License Practical Nurse #2 stated they crushed Resident #8's medication because the resident took them better that way. License Practical Nurse #2 was unable to provide a physician's order to crush medications for this resident. License Practical Nurse #2 stated they were unaware that the above listed medications were not to be crushed. They stated they would notify Director of Nursing #1.During an interview on 08/28/2025 at 10:45 AM, Nurse Practitioner #1 stated that a provider's order was required for nurse to crush medications. If a resident was unable to take medications whole, medications that specifically were not to be crushed would not be ordered for that resident. An alternative medication would be prescribed, if not available in a liquid form.During an interview on 08/28/2025 at 11:00 AM, Director of Nursing #1 stated currently they did not have a (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse educator. They stated the Assistant Director of Nursing previously fulfilled the role. They stated they were in the process of training a unit manager to assume this responsibility. Director of Nursing #1 stated all nurses received medication administration training upon hire that included a preceptorship, observation and competency signoff. 10 New York Codes, Rules, and Regulations 415.12 (m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 for five (5) of five (5) medication carts reviewed. Specifically, (a.) two (2) narcotic lock boxes were broken; (b.) two (2) expired medications were found in medication room; (c.) three (3) bottles of eye drops had no open or expiration dates; and (d.) five (5) insulin pens did not have an open and/or expiration date.This is evidenced by:The facility's Policy and Procedure titled, Medication Storage, effective 03/21/2022 documented Medications housed on premises are stored in the medication rooms or medication carts according to the manufacturer's recommendations. All medications are stored in designated areas which are sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. 1. Narcotics and Controlled Substances: Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key. This includes refrigerated medications, such as Marinol. Only authorized personnel have access to medication storage areas. Insulin Pens are stored in separate plastic bags in the top drawer of the medication cart if being used. Each person and type of insulin. For example: If a resident is on regular and Lantus, they both need a bag) If unused they are stored in separate plastic bags in medication room refrigerator.The facility ' s Policy and Procedure titled, Medication Nurse Routine last revised 12/19/2024, documented all Medication Nurse duties are performed by licensed personnel. Procedures will be performed as follows by all staff uniformly. During the medication pass read orders from electronic medical record, compare prescription label on blister pack to medication order. Remember the five (5) rights: a) right medication b) right resident c) right time d) right dose e) right route. Also check expiration dates.During an observation on 08/27/2025 at 1:00 PM, the Catskill Unit Medication Room Narcotic Box A/B outside lock left ajar. In an interview, License Practical Nurse #4 stated the lock had been broken for over two (2) years. The Catskill Unit medication room also contained a bottle of prescribed Listerine Original mouthwash for Resident #49 with an expiration date of 09/2024.During an observation on 08/27/2025 at 1:20 PM, Catskill medication cart C/D contained one (1) Lispro; two (2) Lantus; one (1) glargine insulin pens with no open and or expiration dates. The cart also contained one (1) bottle of Refresh eye drops with an expiration date of 08/07/2025. The Catskill medication cart A/B contained one (1) lispro insulin pen with no open and or expiration date.During an observation on 08/27/2025 at 1:50 PM, The Adirondack Unit medication room narcotic lockbox C/D outside lock was not secured leaving the outside cabinet door ajar. The Adirondack unit medication cart A/B contained one (1) bottle of timolol eye drops and one (1) bottle of Systane eye drops with no open and or expiration dates.During an interview on 08/27/2025 at 2:10 PM, Administrator #1 was made aware of the broken narcotic lock boxes on Catskill and Adirondack units. Administrator #1 stated they would immediately contact maintenance to have locks repaired.During an interview on 08/28/2025 at 10:31 AM, Director of Nursing #1 stated it was the responsibility of the medication cart nurse to ensure the medication cart was clean and orderly. All medications including insulins and eye drops should be labeled with the open and expiration dates written on the bottle. 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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview during the recertification survey, the facility did not store, prepare, distribute or serve food in accordance with professional standards for food service safety in the main kitchen and two (2) of three (3) kitchenettes. Specifically, expired food was not discarded, a compatible test kit to measure concentration of chemical sanitizer used to manually sanitize food contact equipment (test kit) was not provided, food temperature thermometers were not calibrated, equipment was not in good repair, and equipment was not clean.This is evidenced by:During observations on 08/25/2025 at 10:17 AM: Thickened cranberry juice with use-by dates of 07/09/2025 & 08/12/2025 were found in the storeroom on the shelf with the common stock. The concentration of chemical sanitizer used to manually sanitize food equipment could not be checked; the facility did not have the correct test kit. The label on the bottle of concentrated sanitizer stated that the sanitizer is to be diluted to between 200 and 400 parts per million when sanitizing food contact surfaces. The label of the test kit for checking the sanitizer concentration did not have color graduations that exceeded 400 parts per million and could not test sanitizer concentrations exceeding the manufacturer specifications. Two (2) of three (3) food temperature thermometers were found not in calibration when tested in a standard ice-bath method as follows: 38 degrees Fahrenheit and 39 degrees Fahrenheit. The wet floor sign had cracked and broken plastic and was in disrepair. The following equipment and areas were soiled with food particles or grime: microwave oven, can opener & holder, knife holder, utility drawer, floor next to door frame in janitor closet, wet floor signs.During observations on 08/25/2025 at 3:08 PM: In the A-Unit Kitchenette, the refrigerator door gasket was split and in disrepair, and the left-most drawer and the bottom of cabinets were soiled with sticky drips of food. In the B-Unit Kitchenette, left-most drawer was soiled with sticky drips of food.During an interview on 08/25/2025 at 11:06 AM, Assistant Director of Food Service #1 stated they would calibrate the thermometers, discard the expired cranberry juice, and have the soiled items and areas found cleaned. They stated that they would contact the maintenance department to obtain a wrench for calibrating the analog thermometer and replacing the broken wet floor sign and would contact their chemical supply vendor to obtain the correct sanitizer test papers.New York Codes, Rules, and Regulations Title 10 S415.14(h)Chapter 1 State Sanitary Code Subpart 14

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and interviews during the recertification survey, the facility did not maintain a pest-free environment and an effective pest control program in the main kitchen. Specifically, insect infestation was found in the main kitchen janitor closet.This is evidenced by:During observations on 08/25/2025 at 10:17 AM, small fruit flies were found in the janitor closet around the floor sink.The document titled; Pest Control Inspection Log and dated 02/27/2025 through 07/28/2025 documented that the facility was last treated for fly infestation on 02/27/2025.During an interview on 08/25/2025 at 11:06 AM, Assistant Director of Food Service #1 stated that the pest control vendor would be contacted to address the fly issue. New York Codes, Rules, and Regulations Title 10 S415.29(j)(5)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification and abbreviated survey (Case # 684171), the facility did not ensure the residents' right to be free from abuse and neglect for two (2) (Resident #s 89 and 109) of two (2) residents reviewed for abuse and neglect. Specifically, (a.) on 6/10/2025, Resident #89 who was care planned to be observed closely when not in their room, was left unattended and struck Resident #109 with their walker; and (b.) on 6/22/2025, Resident #89 was sprayed in the face with hot sauce by Resident #63. This is evidenced by: The Facility's Policy titled; Resident Abuse Prevention, dated 05/2025, documented that the purpose was to provide residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The policy documented that the facility shall identify, correct, and intervene in situations in which abuse, neglect, mistreatment, or misappropriation of property may be more likely to occur. Procedures documented included, but were not limited to, supervision of staff, which shall include identification of inappropriate behaviors, such as using derogatory language, rough handling, ignoring residents while giving care, or directing residents in need of toileting to urinate or defecate in their beds or briefs, and counseled when performance is not acceptable.Resident #89Resident #89 was admitted to the facility with Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavior), dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #89 rarely or never made themselves understood, rarely or never understand others, and had severe cognitive impairment.The Comprehensive Care Plan for behaviors, dated 06/02/2025, documented on 11/08/2021 that Resident #89 had behavior issues as evidenced by screaming, yelling, and causing distress to self and others related to their Alzheimer's Disease, Dementia, and was hard to redirect at times. On 2/15/2022, Resident #89 was care planned to be closely observed when not in their room. The facility's Investigative Report dated 6/22/2025 documented that Resident #89 was standing next to Resident #63, whom they were not supposed to be near due to a prior incident in December of 2024. Staff noticed that Resident #89 was nearby and went to separate them. Before the staff person was able to reach them, the Resident #63 sprayed hot sauce into Resident #89's eyes. During the investigation, the staff asked the resident why they had sprayed the sauce in Resident #89's eyes, and Resident #63 stated it was because the resident wanted hot sauce. Staff assessed the resident, flushed their eyes, and moved them back to their own unit. During an interview on 08/27/2025 at 3:35 PM, Certified Nurse Aide #1 stated that they were feeding another resident in their room when they heard the incident and did not see the actual act. They came out of the room and noticed the resident with a red substance on their face being escorted by the nurse. They stated that Resident #89 resided on the A unit and wandered the facility a lot and was supposed to be closely watched, as there have been multiple incidents with them and other residents.During an interview on 08/29/2025 at 3:15 PM, Certified Nurse Aide #2 stated they were not working that day of the incident but knew the residents well. They stated that Resident #89 wandered a lot throughout the facility and should have been observed when not on the unit. They stated they were unsure whether or not they were being observed. uring an interview on 8/29/2025 at 10:25 AM, Licensed Practical Nurse #3 stated that they remembered the incident. They stated that Resident #89 was next to the other resident when they attempted to move them and separate them. They stated that they did not get to them in time, and Resident #89 was sprayed in the face with hot sauce. They stated that they removed the resident, rinsed the patient's face, and flushed their eye. They stated that they reported the incident to their supervisor. Attempted phone interview on 09/02/2025 at 12:35 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM with Registered Nurse #2, who was the Director of Nursing at the time of the incident, was unsuccessful. Resident #109Resident #109 was admitted to the facility with dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), chronic obstructive pulmonary disease (a group of lung diseases that cause airflow obstruction and breathing difficulties), and hypertension (a condition where the force of your blood against the walls of your arteries is too high). The Minimum Data Set, dated [DATE], documented that Resident #109 sometimes made themselves understood, sometimes understand others, and had severe cognitive impairment.The facility's Investigative Report dated 6/10/2025 documented that Resident #109 was walking in the hall toward Resident #89. Resident #89 struck Resident #109 with their walker, and Resident #109 retaliated and struck Resident #89 with a closed fist. The report documented that the force of both strikes was not strong enough to cause injury, and residents were separated. It was documented that neither resident was in their respective units. A review of progress notes dated 6/10/2025 at 4:52 PM, documented that Resident #109 was ambulating down the B unit hallway when Resident #89 started to hit them with their walker. Resident #109 turned and struck Resident #89 in the face with a closed fist. Nursing aides immediately separated residents. Upon assessment, Resident #109 did not have any injuries and had no recollection of the incident due to memory impairment.During an interview on 08/27/2025 at 3:35 PM, Certified Nurse Aide #1 stated that they remembered the incident and saw it happen. They stated that Resident #89 struck Resident #109 with their walker, and Resident #109 then struck Resident #89. They immediately responded and separated both residents. They stated that the residents reside in unit A and frequently wander the facility. They stated that they frequently saw Resident #89 striking individuals with their walker or running into them in the hallway. During an interview on 08/29/2025 at 3:15 PM, Certified Nurse Aide #2 stated that they remembered the incident and saw it happen. They stated that Resident #89 struck Resident #109 with their walker, and Resident #109 then struck Resident #89. They immediately responded and separated both residents. They stated that the residents reside in unit A and frequently wander the facility. They stated that they frequently see Resident #89 striking individuals with their walker or running into them in the hallway. During an interview on 09/02/2025 at 12:10 PM, Director of Nursing #1 stated there should be a mechanism to monitor behaviors if that's what the care plan says. Attempted phone interview on 09/02/2025 at 12:35 PM with Registered Nurse #2, who was the Director of Nursing at the time of the incident, was unsuccessful. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews during a recertification and abbreviated (Case #684171) survey, the facility did not ensure the facility implemented a comprehensive person-centered care plan for each resident for one (1) (Resident # 89) of 24 residents reviewed for comprehensive care plans. Specifically, supervision was not provided for the resident as directed by the comprehensive care plan for Resident # 89. This is evidenced by:The Policy and Procedure titled; Interdisciplinary Care Planning, last reviewed 4/16/2025, stated the interdisciplinary team would develop comprehensive care plans and the care plan must reflect intermediate steps for each outcome objective and staff would use these objectives to monitor resident progress. Also, that using the resident's diagnosis sheet, the care plan would be completed pm which problems were active and applied to the resident's diagnosis/illness.Resident #89 was admitted to the facility with Alzheimer's disease (a progressive brain disorder that primarily affects memory, thinking, and behavior), dementia with behavior disturbances (behavioral and psychological symptoms that accompany dementia, affecting a significant portion of those living with the condition), and hypertension. The Minimum Data Set, dated [DATE], documented that Resident #89 rarely or never made themselves understood, rarely or never understand others, and had severe cognitive impairment.Resident #89's census documented the resident resided on the A unit throughout their facility stay.The Comprehensive Care Plan titled; (Resident) is/has the potential to be physically aggressive related to anger, dementia, poor impulse control last reviewed 6/05/2025 Intervention close observation when not in room dated 7/09/2021.The Comprehensive Care Plan titled, Resident requires assistance with ADL functions included the intervention requires one to one supervision when ambulating off unit for safety and re-direction, dated 1/30/2024.The Task List Documented Resident #89 required one to one supervision when off the unit ambulating for safety initiated 10/3/2023.Resident #89 was involved in multiple resident-to-resident interaction involving physical abuse on 12/22/2024, 6/10/2025 and 6/22/20205.The Incident Report dated 12/22/2024 documented Resident #89 was found in another resident's room on another unit after an altercation. The report documented staff was alerted Resident #89's location after Resident #89 was heard crying out.The Incident Report dated 6/10/2025 documented Resident #89 was walking down the hallway on the B unit when they started hitting another resident with their walker.The Incident Report dated 6/22/2025 documented Resident #89 was near a resident on another unit they had had a documented negative interaction with before and was not separated until an incident had occurred.During an interview on 08/27/2025 at 3:35 PM, Certified Nurse Aide #1 stated that the resident resided on the A unit and wandered the facility a lot and was supposed to be closely watched, as there have been multiple incidents with them and other residents. During an interview on 08/29/2025 at 3:15 PM, Certified Nurse Aide #2 stated that Resident #89 wandered a lot throughout the facility and should be observed when not on the unit. They stated they were unsure whether or not they were observed at the time of the incidents.During an interview on 09/02/2025 at 12:10 PM, Director of Nursing #1 stated that interventions on a resident's care plan were to be implemented as written. 10 New York Codes, Rules, and Regulations 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335704	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnsville Rehabilitation and Nursing Center	7 Timmerman Avenue Saint Johnsville, NY 13452

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, record review, and interview during the recertification survey, the facility did not ensure garbage and refuse was disposed properly. Specifically, the garbage dumpsters were not placed on hard & level surfaces, and one dumpster was not rodent proof.This is evidenced by:During observations on 08/25/2025 at 10:50 AM, 1 of 4 dumpsters did not have a drain plug and was not rodent proof, and four (4) of four (4) dumpsters were placed on gravel and dirt lawn and not on a hard & level surface (as stated on the directions posted on the dumpster).During an interview on 08/25/2025 at 11:06 AM, Assistant Director of Food Service #1 stated they would contact the maintenance department have hard level surfaces installed for the dumpsters and the missing drain plug installed. New York Codes, Rules, and Regulations Title 10 S415.14(h)Chapter 1 State Sanitary Code Subpart 14-1