STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335732	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Gardens Skilled Living Center	800 West Chestnut Street Rome, NY 13440

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37516 Based on observation, record review and interviews during the recertification survey conducted 9/5/2024 - 9/11/2024, the facility failed to consult with the physician when there was a significant change in the resident's physical status for 1 of 4 residents (Resident #79) reviewed. Specifically, Resident #79 had a continuing, unplanned weight loss and the medical provider was not notified. Findings include: The facility policy, Change in a Resident's Condition or Status, revised 05/2017 documented the nurse would notify the resident's attending physician or physician on-call when there had been a significant change in the resident's physical, emotional, or mental condition. The facility policy, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, revised 9/2017 documented nursing staff would monitor and document the weight in a format which permitted comparisons over time, and nursing staff would report to the physician significant weight gains or losses. Resident #79 had diagnoses including vascular dementia with other behavioral disturbance, gastro-esophageal reflux disease (stomach acid flows back up into the esophagus), and dysphagia (difficulty swallowing). The 8/7/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required set-up or clean-up assist for eating, weighed 126 pounds, had a weight loss of 5% or more in 1 month or 10% or more in 6 months, was not on a physician-prescribed weight loss regimen, was on a mechanically altered diet and had no swallowing disorder. Nurse Practitioner #7 medical orders documented: - 10/20/2023 regular diet, thin liquids, mechanical soft with ground meat consistency. - 3/6/2024 push fluids every shift. - 4/26/2024 weekly weights. - 5/10/2024 180 milliliters Med Pass 2.0 (a nutritional health shake supplement) three times a day during medication pass. The resident's weights were documented as follows: (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1/1/2024 154.4 pounds - 2/1/2024 146.6 pounds (5% loss in 1 month) - 3/1/2024 145.5 pounds - 4/1/2024 141 pounds - 5/6/2024 138.6 pounds - 6/3/2024 137.4 pounds - 7/1/2024 133.8 pounds (13% loss in 6 months) - 8/5/2024 126.4 pounds - 9/2/2024 125.4 pounds (19% loss since 1/1/2024) The Comprehensive Care Plan, with a start date of 11/22/2022 and edited on 8/8/2024, documented the resident was at increased risk for alterations in nutritional status and malnutrition secondary to a diagnosis of dementia and significant, unplanned weight loss at 1/3/6 months. The resident's weight continued to trend downward. A long-term goal, edited on 8/9/2024, documented the resident would maintain a current body weight of 154 pounds, plus or minus 5 pounds. Interventions, edited on 5/15/2024, included provide current diet as ordered; provide supplements as indicated; assess intakes, labs, and weights; and monitor weight status at least monthly if stable; and update medical of significant changes. There was no documented evidence the resident had not met their comprehensive care plan goal weight. Medical provider progress notes by Nurse Practitioner #7 and the Medical Director from 5/8/2024 - 9/3/2024 did not document the resident's unplanned weight loss. Nursing progress notes from 5/7/2024-9/9/2024 did not document the resident's unplanned weight loss. Registered Dietitian #8 documented: - on 5/10/2024 at 1:48 PM the resident's weekly weight was 138.6 pounds. The resident's gradual weight loss had resulted in a 26.8 pound loss over the last 6 months. The plan included the resident walked with an extra sandwich, and Med Pass 2.0 was increased to 180 milliliters three times a day. - on 5/15/2024 at 12:55 PM the resident's weekly weight was 134.4 pounds, a 4.2 pound loss from the previous week. The Interdisciplinary Care Team was informed of the weight loss. The plan was to provide an 8-ounce Health Shake (nutritional supplement) and extra sandwiches three times a day at meals. Cookies and ice cream and a 4-ounce Health Shake were added as between meal snacks. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/3/2024 at 9:44 AM the resident's most recent weight had been 133.8 pounds, a loss of 1.6 pounds in 1 week, 3.6 pounds in 1 month, 7.2 pounds in 3 months and 20.24 pounds in 6 months. The Interdisciplinary Care Team was informed of the weight loss. The resident received fortified cereal at breakfast and fortified mashed potatoes with gravy at lunch and supper. Fortified orange juice was added to breakfast. Would request for medical to evaluate if an appetite stimulant would be appropriate. - on 7/24/2024 at 4:44 PM the resident's weekly weight was 132 pounds and the gradual decline continued. Increasing supplements was not indicated at that time. - on 7/31/2024 at 4:42 PM the resident's weekly weight was 128.6 pounds. This was an ongoing, gradual weight loss despite multiple interventions. Weight loss had been significant. Interdisciplinary Care Team, including medical, were aware of the resident's nutritional status. There was no documented evidence the medical provider evaluated the resident for an appetite stimulant (per the 7/3/2024 at 9:44 AM Registered Dietitian #8's progress note) or that medical was made aware of the resident's nutritional status/significant weight loss (per the 7/31/2024 at 4:42 PM Registered Dietitian #8's progress note). The resident was observed: - on 9/5/2024 at 12:29 PM standing next to their bed. They turned around suddenly, got back into bed, and pulled the blankets over their head. At 12:53 PM lying in their bed. Certified Nurse Aide #12 was nearby and stated they offered the resident their lunch tray but, they flopped back down in bed. Certified Nurse Aide #12 stated breakfast was usually the resident's best meal. - on 9/6/2024 at 10:30 AM lying in bed. When their name was called, they sat up quickly and proceeded to walk out of their room and down the hall. At 10:43 AM Certified Nurse Aide #12 stated the resident had eaten well for breakfast that morning. - on 9/9/2024 at 11:16 AM walking continuously around the entire unit. During an interview on 9/10/2024 at 9:08 AM, Nurse Practitioner #7 stated they expected nursing or dietary to inform them if a resident had a weight loss. There was usually a group electronic mail from the registered dietitian about residents with weight loss so they could come up with a plan. If they were told about a resident with weight loss, they would write a progress note right away. Nurse Practitioner #7 reviewed their electronic mail and provider notes and stated they did not see any documentation regarding Resident #79's significant and continuing weight loss. They stated there were no further interventions they could do, and the current plan remained. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/2024 at 9:59 AM Licensed Practical Nurse Unit Manager #4 stated dietary usually notified them of a resident's weight loss and they or dietary would notify the medical provider. They thought the Interdisciplinary Team knew about Resident #79's continuing weight loss trend. The resident's weight loss was discussed at the last few care plan meetings and the family was aware. The resident did not sit down for long at meals. Medical should be notified of weight loss because they did not want the resident to lose weight so rapidly. They must have dropped the ball on the resident's weight loss because they had seen the resident continuing to lose weight ever since they came from another unit and the resident's weight loss was talked about and a known fact. They were surprised the registered dietitian did not notify medical of the weight loss. During an interview on 9/10/2024 at 11:19 AM Registered Dietitian #8 stated they brought weight changes of residents to morning report. They discussed weight changes, reviewed with nursing, then nursing would bring it to the attention of medical. Resident #79 was on every possible supplement, nourishment, extra sandwiches, and finger foods. This was discussed during care plan meetings. Medical providers did not attend care plan meetings. They brought the resident's weight loss to the attention of Licensed Practical Nurse Unit Manager #4 who should have notified medical. During an interview on 9/11/2024 at 9:08 AM the Medical Director stated they were not aware of Resident #79's continuing downward weight loss over the past year and expected the Nurse Manager to inform them. If they knew of a resident's weight loss, they looked for non-pharmacological solutions first. Family representatives would be included in solutions to weight loss. With dementia residents they asked families what expectations they had for their resident's plan of care and nutrition. If all the non-pharmacological solutions were looked at and weight loss continued, then they might trial mirtazapine (an anti-depressant medication sometimes used as an appetite stimulant). During an interview on 9/11/2024 at 10:05 AM, the Director of Nursing stated Licensed Practical Nurse Unit Managers could notify medical about a resident's weight loss. There was also a communication book on the unit and things rarely got missed. Licensed Practical Nurse Unit Manager #4 edited resident care plans with approval from a registered nurse. The nutrition care plan for Resident #79 was written by Registered Dietitian #8 so they would be the one to update the care plan. Resident #79's weight loss was discussed in care plan meetings with the resident's family and medical notification must have slipped through the cracks. 10 NYCRR 415.3(e)(2)(ii)(b,c)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 33421 Based on record review and interview during the recertification survey conducted 9/5/2024-9/11/2024, the facility did not ensure residents were screened for a mental disorder or intellectual disability prior to admission for 1 of 18 residents (Resident #52) reviewed. Specifically, there was no documented evidence Resident #52 had a Preadmission Screening and Resident Review (PASARR, New York State Department of Health form 695) completed by a qualified screener within the required time frame prior to admission to the facility. Findings include: The undated facility policy, Screens, documented every admission would have a completed screen prior to being accepted and arriving to the facility. The admission department would obtain the completed screen and the social worker would ensure it was in the medical record. The Admissions Department would ensure that if a Level II evaluation was required, that the necessary information was completed and processed. The Director of Admissions would conduct a quarterly audit to ensure compliance. Resident #52 had diagnoses including anxiety, depression, and Post Traumatic Stress Syndrome. The 12/25/2022 admission Minimum Data Set assessment documented the resident had intact cognition, had depression and Post-Traumatic Stress Disorder, and received an antidepressant daily. The 8/23/2022 Preadmission Screening and Resident Review from a different facility admission documented Resident #52 could not receive restorative services within the community. The resident did not have a screen done prior to the current 12/2022 admission. The 1/2/2023 admission Comprehensive Care Plan documented the resident resisted care, was a lateral transfer from another facility, needed assistance with activities of daily living, preferred activities that identified with prior lifestyle, and had slight confusion. Interventions included educate, notify physician or social worker of any changes in mood/behavior, assist with activities of daily living as planned, provide activities calendar, and provide early interventions as needed. During an interview on 9/10/2024 at 1:50 PM, the Director of Admissions stated each resident should have a screen done prior to admission to the facility and the screen had to have been done within 90 days prior to admission. Resident #52's screen was from the previous facility and exceeded the 90-day window. The resident did not have a significant psychiatric history and was not developmentally disabled. The Admissions Department was responsible for ensuring the screen was obtained and within regulations. They must have made an error calculating the date at admission time. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/2024 at 2:00 PM, the Director of Social Services stated the purpose of the screen was to identify if a resident had a significant mental illness or delay that required special services. Th Admissions Department was responsible for obtaining the screen and notifying social services if a Level II was needed/done signifying what special services were recommended. All residents required a Level I screen to determine if a Level II was required. The screen should be done within 90 days prior to admission. Random audits were done within the facility to ensure compliance. Somehow, Resident #52's screen was missed and was not within the required time frame prior to admission. The resident had no significant issues and did not need specialized psychosocial care. The resident's care was also monitored by an outside agency on a routine basis due to post-traumatic stress syndrome. 10NYCRR 415.11(3)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 46276 Based on observation, record review, and interviews during the recertification survey conducted 9/5/2024-9/11/2024, the facility did not ensure residents who required dialysis (a process that filters blood for the kidneys) received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #42) reviewed. Specifically, Resident #42 did not receive ongoing assessment of their condition and monitoring for complications before and after dialysis treatments, or ongoing communication and collaboration with the dialysis facility. Findings include: The undated facility policy, Dialysis, documented residents going out of the building for hemodialysis should take communication sheets with them to allow for ease of communication between facilities; changes in resident status should be communicated to nephrology (kidney specialists) staff in a timely manner. Resident #42 had diagnoses of end-stage renal (kidney) disease and dependence on renal dialysis. The 5/13/2024 Minimum Data Set assessment documented the resident had intact cognition, did not reject care, and required hemodialysis treatments. The Comprehensive Care Plan initiated 8/16/2022 and revised 8/16/2024 documented the resident had end-stage renal disease and required dialysis. Interventions included assess the resident for mental status/general condition, review communication book upon resident's return from the dialysis center, assure resident took communication book with them to the dialysis center, check hemodialysis access site and monitor for signs and symptoms of bleeding/infection or any abnormality and notify the physician, and monitor vital signs and dialysis as scheduled. Physician orders documented: - on 1/31/2024 hemodialysis catheter, ensure no drainage to bandage, covered at all times, dialysis only to touch. - on 3/4/2024 documented the resident was to receive hemodialysis on Mondays, Wednesdays, and Fridays from 7:00 AM- 3:00 PM; dialysis notes on every dialysis day on Monday, Wednesday, and Friday. The 9/1/2024-9/9/2024 Treatment Administration Record documented hemodialysis catheter, ensure no drainage to bandage, covered at all times, dialysis only to touch, with a start date of 1/31/2024. The Treatment Administration Record had x's from 9/1/2024-9/3/2024 for days, evenings, and nights; and for 9/4/2024 days and evenings. Nursing progress notes dated 8/8/2024-9/6/2024 did not include assessments of the resident's dialysis access site or monitoring for signs and symptoms of bleeding. There were no pulses, respirations, or blood pressures documented from 8/9/2024-9/9/2024. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/2024 resident care instructions documented dialysis per schedule and assure resident took communication book with them to dialysis. The resident's dialysis communication book was unable to be located in their room or on the nursing unit. The last dialysis communication sheet in the electronic medical record was dated 6/23/2023. The dialysis center flowsheets scanned into the resident's electronic medical record documented the resident's vital signs and weights were obtained at the dialysis center. A 9/10/2024 at 1:37 PM email received from the Administrator documented there were no Registered Nurse assessments or staff education for dialysis. During an observation and interview on 9/5/2024 at 11:06 AM, Resident #42 was sitting in their room in a wheelchair. They stated they received dialysis. A dry sterile bandage was on the Resident's right upper chest wall. During an observation and interview on 9/9/2024 at 9:25 AM the resident was sitting in their wheelchair in the front lobby. They stated they were going to dialysis, they did not have a dialysis communication book, and staff were supposed to check their heart rate and other vital signs before they went. This was only done occasionally. During an interview on 9/9/2024 at 11:21 AM Certified Nurse Aide #14 stated the resident required assistance to get up and dressed on dialysis days and the night shift staff got the resident up before they arrived. Certified Nurse Aide #14 stated they were unsure if the resident needed anything or was required to bring anything with them to dialysis. During an interview on 9/9/2024 at 11:24 AM Licensed Practical Nurse #15 stated Resident #42 went to dialysis on Monday, Wednesday, and Fridays. They thought the resident had a sheet the dialysis center filled out. Dialysis weighed the resident, and the nurses recorded it when the resident returned. Licensed Practical Nurse #15 stated they were unsure if staff were required to do anything else when the resident returned except for administering their evening medications. During an interview on 9/9/2024 at 1:44 PM with Registered Nurse Unit Manager #13, they stated they did not know where the resident's communication book was and thought Licensed Practical Nurse #16 took care of the book. They stated the resident was not assessed by them when they returned from dialysis, they were unaware an assessment had to be completed. They thought licensed practical nurse #16 weighed the resident when they returned and took vital signs when they were needed. During an interview on 9/10/2024 at 10:00 AM, the Director of Nursing stated they were familiar with Resident #42, and they received dialysis treatments three days per week. They were unaware a dialysis resident required an assessment when they returned and thought if the resident had complications, that dialysis would let them know. 10 NYCRR 415.12(k)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35045 Based on observation, interview, and record review during the recertification survey conducted 9/5/2024-9/11/2024, the facility did not ensure food was prepared, distributed, and served in accordance with professional standards for food service in the facility's main kitchen. Specifically, in the main kitchen, food was not stored at safe temperatures in the walk-in cooler, there were uncleanable floor surfaces, the toaster was not clean, and the dishwasher instructions were not clean and legible. Findings included: The facility policy, Cleaning and Sanitation of Food Service Areas, revised 10/2022 documented staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The facility policy, Food Receiving and Storage, revised 5/2024 documented foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law and refrigerated food will be stored in such a way that promotes air circulation around food storage containers. Improper Cooling: During an observation and interview on 9/5/2024 at 4:03 PM, a large hotel pan (6 inch deep) of cooked pasta covered in plastic wrap, located on the lower shelf just inside to the right of the walk-in cooler, measured at 65 degrees Fahrenheit. The Food Service Director stated the pasta was cooked about two hours ago. They cooked the pasta, drained it, rinsed it with cool water, added ice, and let the pasta set out for an hour. [NAME] the pasta was below 70 degrees Fahrenheit, it was placed into the walk-in cooler. They stated they were familiar with the cooling requirements and the cook who made that pasta was new and should not have put the pasta in that deep of a pan and should have used a shallow pan to help the pasta cool quicker. Cooling was supposed to be documented and checked in the logbook. The cooling logbook was reviewed, the logbook was blank, and there was no entry for pasta cooling. Uncleanable surfaces and equipment in disrepair: During an observation on 9/5/2024 at 9:48 AM, the kitchen floor by the main oven had unclean areas on the left side below the oven. The toaster had food debris on it and was not clean. The floor tiles in the main dish washing area were missing and there were stains on the walls above the main dish washing area. During an observation on 9/6/2024 at 3:56 PM, there were broken floor tiles in front of the 3 bay sink area. The wall above the sinks had missing tiles and the wall was unclean. (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 observation and Interview on 9/6/2024 at 1:25 PM, Dietary Aide #11 stated they knew how to power on the dish washer and the minimum temperatures for the wash and rinse cycle were posted on the wall outside of the dish machine area. They were not aware there were instructions on the machine. and that the instructions should be easily read. They received training on how to use the dish machine. They stated it was important to know the required washing temperature to ensure the dishes were sanitized properly and prevent germs on the dishes. During an interview on 9/9/2024 at 3:36 PM, the Food Service Director stated the kitchen had a cleaning schedule that included the dirtiest use areas. The floors should be cleaned every night with mop and broom. The dish person was responsible to clean the dishwashing area floor and walls. They stated the broken floor tiles should be replaced, they cannot clean them properly, and dirt could get trapped in the area where the tile was missing. They stated they would put in a work order to get the tiles replaced. The toaster should be cleaned every day. The parts that were able to be removed should be run through the dishwasher to remove any food debris to ensure food does not build up and cause a fire within the toaster. They were not aware that the specifications and instructions for the dish machine were in an area that staff were unable to read it. The director stated the instructions were not easily seen, as the area was worn and dirty. 10NYCRR 415.14(h) 43754 Based on observation, interview, and record review during the recertification survey conducted 9/5/2024-9/11/2024, the facility did not ensure food was prepared, distributed, and served in accordance with professional standards for food service in the facility's main kitchen. Specifically, in the main kitchen, food was not stored at safe temperatures in the walk-in cooler, there were uncleanable floor surfaces, the toaster was not clean, and the dishwasher instructions were not clean and legible. Findings included: The facility policy, Cleaning and Sanitation of Food Service Areas, revised 10/2022 documented staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. The facility policy, Food Receiving and Storage, revised 5/2024 documented foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law and refrigerated food will be stored in such a way that promotes air circulation around food storage containers. Improper Cooling: (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 9/5/2024 at 4:03 PM, the lower shelf, just inside the walk-in cooler, had a large hotel pan (6 inches deep) of plastic wrap covered, cooked pasta. The pasta's temperature was measured at 65 degrees Fahrenheit. The Food Service Director stated a cook made the pasta about three hours ago. They cooked the pasta, drained it, rinsed it with cool water, added ice, let it sit out for an hour until it was below 70 degrees Fahrenheit, and placed it into the walk-in cooler. It had been there for about two hours. They stated they were familiar with the cooling requirements and the cook who made that pasta was new and should not have put the pasta in that deep of a pan. They should have used a shallow pan to help the pasta cool quicker. They stated cooling was supposed to be documented in the logbook, however, the logbook was blank, and there was no entry for cooling the pasta. They stated the covered pan of pasta was not meeting with cooling requirements because it had only dropped about 5 degrees in the last two hours. Uncleanable surfaces and equipment in disrepair: During an observation on 9/5/2024 at 9:48 AM, the kitchen floor by the main oven had unclean areas on the left side below the oven. The toaster had food debris on it and was not clean. The floor tiles in the main dish washing area were missing and there were stains on the walls above the main dish washing area. During an observation on 9/6/2024 at 3:56 PM, there was some food, debris, and grime under the cooking equipment. The toaster had cooked on food debris inside the unit, and some burn marks on the housing (not smooth and easily cleanable surfaces). The dish machine specifications could not be read because of the grease and grime on the specification plate. The exterior of the machine was coated with a dusty greasy build up of grime. During an observation on 9/6/2024 at 3:56 PM, there were broken floor tiles in front of the 3 bay sink area. The wall above the sinks had missing tiles and the wall was unclean. During an observation and Interview on 9/6/2024 at 1:25 PM, Dietary Aide #11 stated they knew how to power on the dish washer and the minimum temperatures for the wash and rinse cycle were posted on the wall outside of the dish machine area. They were not aware there were instructions on the machine. The instructions should be easily read. They received training on how to use the dish machine and it was important to know the required washing temperature to ensure the dishes were sanitized properly and to prevent germs on the dishes. During an interview on 9/9/2024 at 3:36 PM, the Food Service Director stated the kitchen had a cleaning schedule that included the dirtiest use areas. The floors should have been cleaned every night with a mop and broom. The dish person was responsible to clean the dishwashing area floor and walls. The broken floor tiles should have been replaced, they could not be cleaned properly, and dirt could get trapped in the area where the tile was missing. The toaster should be cleaned every day. The parts that were able to be removed should be run through the dishwasher to remove any food debris to ensure food did not build up and cause a fire within the toaster. They were not aware that the specifications and instructions for the dish machine were in an area that staff were unable to read them, and the instructions were not easily seen, because the area was worn and dirty. 10NYCRR 415.14(h)