| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630<br><br>Based on record review and interview during the recertification survey, the facility did not ensure each resident was treated with respect and dignity and cared in a manner and in an environment that promoted maintenance or enhancement of their quality of life for 4 (Resident #s 13, 17, 62, and 364) of 40 residents reviewed. Specifically, [a.] Resident #13 was unable to attend activities of their choice as their wheelchair was not able to fit through the interior doorways to the activities room, which caused the resident to feel excluded, [b.] Resident #17 expressed feeling like a burden and was uncomfortable asking for help because of staff ' s unprofessionalism, [c.] Resident #62, was observed on 1/13/2025 at 11:40 AM with matted, greasy hair, fully clothed, and was malodorous. , and [d] Resident #364 was observed on 1/13/2025 at 1:41 PM, with a urinary catheter drainage bag that was not covered with a privacy pouch.<br><br>This is evidenced by:<br><br>The Policy and Procedure titled, Quality of Life/Dignity, revised 5/28/2024, documented each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Policy implementation documented, residents would be treated with dignity and respect at all times. ' Treated with dignity ' was defined as the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth, residents would be assisted in attending the activities of their choice, including activities outside the facility, and residents would be assisted in transporting throughout the facility as needed. The policy documented staff would speak respectfully to residents. Demeaning practices and standards of care that compromise dignity were prohibited. Staff would promote dignity and assist residents as needed by promptly responding to the resident ' s request for toileting assistance and other needs.<br><br>The Policy and Procedure titled, Catheter Guidelines; Urinary, revised 9/11/2023, documented urinary catheter use would adhere to the principles of dignity to include discreet use and privacy (e.g. covering urinary catheter drainage bags).<br><br>Resident #13:<br><br>Resident #13 was admitted to the facility with diagnoses of acute and chronic respiratory failure with hypoxia (low level of oxygen in the bloodstream), morbid (severe) obesity and type 2 diabetes mellitus without complications. The Minimum Data Set (an assessment tool) dated 11/12/2024 documented the resident was cognitively intact, could be understood, and understand others.<br><br>(continued on next page) |



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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Care Plan for Resident #13 titled, does not express an interest in recreational activities, initiated 8/4/2023, documented a goal that the resident ' s wishes related to their recreational/leisure area would be respected and listed respect resident refusals as an intervention/task.<br><br>During an interview on 1/13/2025 at 11:39 AM, Resident #13 stated their wheelchair did not fit through the activities entrance and they would like to go to more activities like bingo.<br><br>During an observation on 1/16/2025 at 9:12 AM, Resident #13 ' s wheelchair was brought to the activities room. The wheelchair was not able to be pushed through the interior doorways that led into the activities room as it was wider than the doorways.<br><br>During a subsequent interview on 1/16/2025 at 11:46 AM, Resident #13 stated, ' I feel kinda left out a little bit. I do like going to bingo. I ' m what you call a people person. I like talking to people. It ' s not that I don ' t want to go down there, but I can ' t fit through the doors. ' Resident #13 explained that for them to attend an activity in the activities room, they needed to have their wheelchair pushed through an exterior door on their unit that leads to an exterior door of the activities room, which was able to be opened to accommodate the width of their wheelchair. This meant they needed to go outside to have access to the activities room. Resident #13 stated they would do this during the good weather to be able to attend activities, but they rather do it year-round if they could. Resident #13 stated if their wheelchair fit through the interior doors to the activities room, they would attend activities more often.<br><br>During an interview on 1/16/2025 at 9:12 AM, Certified Nurse Aide #2 stated Resident #13 ' s wheelchair did not fit through any of the interior doors. Stated that when the weather was nice, they would bring Resident#13 into the activities room from one of the outside doors, but the other residents would watch, and it made Resident #13 feel uncomfortable. Now resident #13 spends their time on the unit.<br><br>During an interview on 1/17/2025 at 11:24 AM, Corporate Recreation Director #1 stated Resident #13 did say they wanted to go to activities. Corporate Recreation Director #1 stated they had Certified Nurse Aides show them the path they used to get Resident #13 into the activities room from the outside. They stated Resident #13 stated if the weather was nice, they did not mind being brought to activities like this, but if the weather was not nice, Resident #13 stated they did not want to go outside. Corporate Recreation Director #1 stated Certified Nurse Aides stated for the most part, the facility did a good job with maintaining the sidewalk used to bring Resident #13 to the activities room, but there was a ' rut ' (deep track) that could make it hard to push the wheelchair. They stated the aides would get by it and they got through it.<br><br>Resident #17:<br><br>Resident #17 was admitted to the facility with diagnoses of anxiety disorder, paraplegia (inability to voluntarily move the lower parts of the body), and stage 4 pressure ulcer of right buttock. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>The Certified Nurse Aide Task Report dated January 2025, documented the resident required assistance with catheter care/bowel incontinence and bowel movements every shift.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/16/2025 at 12:57 PM, Resident #17 stated staff need an in-service on professionalism. Stated staff made them feel like they were a burden when they asked for things. Resident #17 stated they needed help when they needed to have a bowel movement and staff ' s unprofessionalism made them feel uncomfortable to ask for help. Stated they knew there was a lot of residents that felt like that. Stated they heard staff talking about things that were not Resident #17 ' s business. Resident #17 stated staff would talk about their own, other staff ' s, and residents ' personal business. Resident #17 stated staff need an in-service on dignity.<br><br>During an interview on 1/23/2025 at 4:22 PM, Registered Nurse #2 stated most staff working in the facility were agency staff. Stated there was not a lot of facility hired staff. Stated agency staff did receive orientation but did not know what it entailed. Their expectation was that all staff would be respectful to all residents. Stated they had not observed any staff being disrespectful but was not in the building during the evenings and nights. Stated a supervisor was in the building during those times.<br><br>Resident #62:<br><br>Resident # 62 was admitted to the facility with diagnoses of pubic ramus fracture (a fracture of the pubic bone), primary osteoarthritis (arthritis of the bones and joints), left shoulder, and muscle weakness. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact, could be understood, and could understand others.<br><br>During an observation on 1/13/2025 at 11:40 AM, Resident #62 was observed seated in a wheelchair in their room, with the door closed. Resident #62 had matted and greasy hair, was fully clothed, and was malodorous. The room was cluttered with personal belongings and their breakfast tray was still present on the bedside table. Resident #62 expressed their frustration that their breakfast tray had sat on the bedside table since 8:00 AM and staff had not come in to remove it. Stated that every day the meal tray would stay on the bedside table until the next meal, when it was replaced with the next tray. Resident #62 reported they shared a bathroom with another resident in an adjoining room. Stated the other resident would lock Resident #62 ' s side of the bathroom door when they used the bathroom and there was a time when the door stayed locked. Stated they put their call light on and waited by the bathroom door for two hours before staff answered the light. Resident #62 reported they were embarrassed because they had been incontinent of stool while they waited for staff to unlock the door,and felt this could have been prevented. Resident #62 could not remember the exact date of the incident but stated it happened on the 3:00 PM to 11:00 PM shift sometime around Christmas. Resident #62 stated the Certified Nurse Aides and Licensed Practical Nurses on evening and night shifts were ' very rude and unhelpful. '<br><br>During an interview on 1/15/2025 at 6:00 PM, Certified Nurse Aide #1 stated they normally work the 3:00 PM to 11:00 PM shift but were often floated to other units. Certified Nurse Aide #1 stated the residents could be demanding. Certified Nurse Aide #1 reported Resident #62 was a demanding resident. Certified Nurse Aide #1 stated they did not remember the bathroom being locked in Resident #62 ' s room. Certified Nurse Aide #1 reported staff tried to answer call bells a quickly as possible, but there had been busy times when it had taken 40 minutes or more. Certified Nurse Aide #1 stated ' These people should be grateful for the care we give them. If not for this place, where would they be? They should treat the aides with respect if they want to get respect ' .<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse # ' s 3 and 4 stated Resident #62 had a shared bathroom. They stated other residents often lock both doors for privacy. This happens frequently in all shared rooms. Licensed Practical Nurse #3 stated that no call light should go unanswered for more than 5 minutes. They stated they were unaware Resident #62 had been locked out of the bathroom and waited 2 hours for someone to answer the call light, causing incontinence. Licensed Practical Nurse #3 stated this should not have happened and it was considered poor care.<br><br>During an interview on 1/22/2025 at 2:04 PM, Social Worker #1 stated they were not aware of the locked bathroom door, but they were aware of concerns about care, voiced by Resident #62 ' s family member. Social Worker #1 reported they checked in on Resident #62 often and they did not think the resident was unhappy. Social Worker #1 stated the resident ' s biggest concern had been about the size of their bed.<br><br>Resident #364:<br><br>Resident #364 was admitted to the facility with diagnoses of unspecified fall, influenza virus A, and other acidosis (a condition where the body has too much acid in its fluids). A Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>The Care Plan for Indwelling Urinary Catheter related to urinary retention, dated 1/8/2025, documented goals that the resident would show no signs or symptoms of urinary infection, and the resident would remain free from catheter-related trauma. Interventions documented change catheter as ordered; ensure tubing was anchored to prevent pulling; and maintain urine collection bag below the level of the bladder.<br><br>During an observation on 1/13/2025 at 1:41 PM, Resident #364 ' s urinary catheter drainage bag was lying flat on the floor. The drainage bag did not have a cloth privacy cover. Resident #364 reported they were admitted to the facility with the catheter in place from their hospital stay. Resident #364 reported the catheter drainage bag had always been uncovered and lying on the floor or on the bed.<br><br>During an interview on 1/14/2025 at 11:00 AM, Resident #364 asked the surveyor about the privacy bag which was covering the catheter drainage bag, ' Why are we suddenly covering this now? '<br><br>During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #3 stated all urinary catheters with exposed drainage bags were required to have a privacy bag and were to be hung below the level of the bladder. Licensed Practical Nurse #3 stated they did not know why Resident #364 did not have a privacy bag to cover their exposed catheter bag on 1/13/2025.<br><br>10 New York Code of Rules and Regulations 415.5(a)<br><br>51131<br><br>51317 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615<br><br>Based on observations, record reviews, and interviews during a recertification survey, the facility did not ensure residents were assessed by an interdisciplinary team to determine their ability to safely self-administer medication when clinically appropriate for 2 (Residents #s 13 and 22) of 2 residents reviewed for self-administration of medication. Specifically, (a.) Resident #13 was observed with their prescribed Albuterol inhaler and Trelegy inhalers on their overbed table and; (b.) Resident #22 was noted to have an Albuterol sulfate hydrofluoroalkane (HFA) inhaler on their overbed table. There was no documented evidence that Resident #s 13 and 22 were assessed to determine their ability to safely self-administer medications, and there was no physician order for self-administration of medications.<br><br>This is evidenced by:<br><br>Facility policy titled Medication-Self Administration created 03/2018, last revised 07/2019 stated criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions. Procedure included, staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the residents upon request. In addition to general evaluation of decision-making capability, the nurse would perform a more specific skill assessment, this could be accomplished on paper or through Electronic Health Record system. If the team determines from this assessment, that a resident cannot fully safely self-administer medications, the nursing staff may determine that the resident could self-administer medications with assistance from the nurse, by storing the medication in the med-cart and having the resident being observed self-administered at the prescribed time Procedure also included, The Electronic Medication Administration Record/Medication Administration Record must identify medications that are self-administered and the medication nurse would need to follow-up with resident as to documentation and storage of medication during each med pass.<br><br>Facility policy titled Medication-Storage created 02/2014 revised 01/2019 stated this center would have Medications stored in a manner that maintained the integrity of the product, ensures the safety of the residents, and is in accordance with Department of Health Guidelines. With the exception of Emergency Drug Kits, all medications would be stored in a locked cabinet, cart, or medication cart that is accessible to only authorized personnel, as defined by facility policy.<br><br>Resident #13<br><br>Resident #13 was admitted to the facility with diagnoses of acute and chronic respiratory failure with hypoxia (a medical condition where the body is unable to effectively exchange oxygen and carbon dioxide in the lungs leading to persistently low levels of oxygen in the blood), type 2 diabetes mellitus without complications (a chronic condition that happens when a person has persistently high blood sugar levels) , and chronic obstructive pulmonary disease with (acute) exacerbation (narrowing of airways in the lungs making it difficult to breathe). The Minimum Data Set (an assessment tool) dated 11/12/2024 documented the resident was cognitively intact, had the ability to make themselves understood and had the ability to understand others.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 01/13/2025 at 11:56 AM, an Albuterol inhaler (a prescription medication used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease) was noted to be present on the overbed table of Resident #13.<br><br>During an observation on 01/15/2025 at 10:25 AM, an Albuterol inhaler (as described above) and a Trelegy inhaler (a prescription inhaler used to treat asthma and chronic obstructive pulmonary disease) was noted to be present on the overbed table of Resident #13.<br><br>A review of Resident #13's medical record did not include documented evidence that the resident was assessed for their ability to self-administer their medications.<br><br>A review of Resident #13's care plan did not include documented evidence that the resident could self-administer their medications.<br><br>A review of the physician orders for Resident #13 dated 03/04/2024 documented Proventil HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT Solution 0.5-2.5 (3) MG/3 ML (Albuterol) to be inhaled orally every four hours every day for shortness of breath to be administered by clinician.<br><br>A review of the physician orders for Resident #13 dated 02/20/2024 documented Trelegy-Elliptia Inhalation Aerosol Powder Breath Activated to be inhaled orally one time a day for chronic obstructive pulmonary disease to be administered by clinician.<br><br>During an interview on 01/15/2025 at 10:25 AM, Resident #13 stated the inhalers were there to help their breathing, The Trelegy was used once a day, and the Albuterol was used four times a day. The nurses were there when it was used. They stated the nurses handed the medication to them and watched them use it. They stated medications were left on the overbed table throughout the day, and at the end of the day after the last time it was used, the nurses kept it on their medication cart. Resident #13 stated they never went through an assessment for administering their own medications and stated, They trust me. They know I'm not going to overdose.<br><br>During an interview on 01/15/2025 at 11:26 AM, Licensed Practical Nurse #1 stated there were no residents that were able to self-administer medications on the unit and they would never leave medications at the bedside. If they found medications at the bedside, they would go to a nurse manager. Licensed Practical Nurse #1 stated there was a protocol for residents to be allowed to self-administer medications, but they were not sure of the protocol because medications were not left at the bedside.<br><br>During an interview on 01/15/2025 at 10:58 AM, Registered Nurse #1 stated there needed to be an order for a resident to be able to self-administer medications. The resident needed to be trained and demonstrate they could use the medication appropriately. Registered Nurse #1 stated they did not have any residents on the unit that they were aware of who could administer their own medications.<br><br>During a follow up interview on 01/21/2025 at 9:31 AM, Registered Nurse #1 stated there were no orders for Resident #13 to have any medications at the bedside.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/21/2025 at 10:12 AM, Director of Nursing #1 stated there were no residents in the building that administered their own medications. They stated if a resident was not capable to administer their own medications independently but could do so with supervision, residents should not have access to the medications until it was provided by Nursing and medications were to be kept locked up on the medication cart.<br><br>Resident #22<br><br>Resident #22 was admitted to the facility with diagnosis of diabetes mellitus, chronic obstructive pulmonary disease (inflammation inside the airways), and anxiety disorder (a type of mental health condition. Those affected may respond to certain things and situations with fear and dread). The Minimum Data Set, dated dated dated [DATE], documented resident was cognitively intact, could be understood, and understand others.<br><br>During an observation on 1/13/2025 at 11:58 AM, Resident #22 was noted to have an Albuterol sulfate hydrofluoroalkane (HFA) inhaler on their overbed table.<br><br>The Medication Administration Record dated 12/30/2024, documented give Ventolin hydrofluoroalkane (HFA) Aerosol solution 108 (90 base) micrograms (albuterol sulfate) 2 puffs inhale orally every 4 hours as needed for wheezing or shortness of breath.<br><br>During an interview on 1/13/2025 at 11:58 AM, Resident #22 stated the nurse gave them the inhaler out of the medication cart because they know when to use it. Resident #22 stated they used the inhaler when they felt they needed it.<br><br>During an interview on 1/15/2025 at 10:29 AM, Licensed Practical Nurse #7 stated to their knowledge no resident at the facility self-administered their medication. If a resident was able to self-administer, there would be an order in the medication administration record.<br><br>During an interview on 01/21/25 at 01:13 PM, Director of Nursing #1 stated there were no residents at the facility who self-administered their medication. If a resident wished to self-medicate, there would be an assessment completed; a doctor's order would be placed in the medication administration record and the care plan would be updated.<br><br>10 New York Codes, Rules, and Regulations: 415.3(f)(1)(vi)<br><br>51317 |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>51317<br><br>Based on observation and interviews conducted during a recertification survey, the facility did not ensure results of the most recent Federal/State survey were posted in a place readily accessible to residents. Specifically, survey results were posted in a place that was not frequented by most residents, visitors, or other individuals; was not in a location that would allow individuals to examine the survey results without having to ask and to maintain privacy to review the results; and there was no documentation on resident units notifying residents of the location of the survey results.<br><br>This was evidenced by:<br><br>During the resident council meeting on 1/14/2025 at 11:07 AM, 4 of 4 residents in attendance verbalized they did not know where the facility had the Department of Health Survey results located.<br><br>During an observation on 01/17/2025 at approximately 10:40 AM, the surveyor observed the facility had a black binder near the entrance area in a plastic holder attached to the wall with incomplete documentation regarding results of surveys for the past three years. There was no prominent sign on the wall indicating what was in the binder.<br><br>During an interview on 01/17/2025 at 10:40 AM, Receptionist #1 stated reports regarding survey results went straight to the Administrator. The reports were not kept at the front desk. Receptionist #1 did not know where reports with results from Department of Health surveys were kept and Receptionist #1 stated there was no sign indicating the survey results were available for anyone to view.<br><br>During an interview on 01/17/2025 at 10:42 AM, Administrator #1 stated, previously there was a sign on the wall above where the survey results were kept indicating results of surveys were available for anyone to view. They stated they would put the sign back up.<br><br>During a subsequent interview on 01/17/2025 at 11:40 AM, Administrator #1 stated there was nothing in the binder for surveys dated 11/30/2023, 1/09/2024, and 5/23/2024. They stated they would put the results from the surveys for the past 3 years.<br><br>10 New York Codes, Rules, and Regulations:415.3(d)(1)(v) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413<br><br>Based on observation and staff interviews during a recertification survey, the facility did not ensure a safe, comfortable home-like environment and effective housekeeping and maintenance services were maintained for 5 (Units A, B, C, D, and G) of 5 resident units. Specifically, for all units, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood; for Unit A, there was not sufficient hot water to the resident's rooms; for Units B, C, D, and G, the bathrooms were not fully cleaned, tidy, and lights in residents bathroom not working.<br><br>This is evidenced by:<br><br>The undated Policy &Procedure, titled Maintenance/Housekeeping Work Order Policy, documented that it was the facility's policy to ensure all areas maintained a clean, comfortable, and well-functioning environment. When problems were identified, employees were required to complete a Maintenance/Housekeeping Work Order.<br><br>Observations:<br><br>Observations on Unit A were as follows;<br><br>-On 1/13/2025 at 12:14 PM, room [ROOM NUMBER] lighting in the bathroom was not fully lit only dimly working and the water was not hot and took approximately 3 minutes to get to a comfortable temperature. The door handle on the inside of room [ROOM NUMBER] sticks and unable to open the door.<br><br>-On 1/13/2025 at 12:59 PM, Handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood.<br><br>-On 1/13/2025 at 3:32 PM, in room [ROOM NUMBER], the toilet was stained with a reddish color and had not been cleaned<br><br>Observations on Unit B were as follows;<br><br>-On 1/13/2025 at 11:49 AM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood.<br><br>-On 1/13/2025 at 12:22 PM, the resident stated that it was hard to regulate the heat in the room which gets very warm sometimes too warm.<br><br>Observations on Unit C were as follows:<br><br>-On 1/13/2025 at 12:41 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood.<br><br>-On 1/13/2025 at 11:49 AM, multiple shared bathrooms were not cleaned and had buildup around toilets and in corners of bathrooms.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

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| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observations on Unit D were as follows;<br><br>- On 1/13/2025 at 12:07 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood.<br><br>- On 1/13/2025 at 11:13 AM, Room A-10 was very dirty. The room was cluttered with equipment, a wheelchair, and a walker. The areas around the bathroom door and entry door in the hinged corner crusted with dirt and dust. The floor and bedside tray were sticky with spilled food.<br><br>- On 1/13/2025 at 4:50 PM, Resident room A-10 still had cluttered equipment in the room as well as uncleaned areas. The resident's floor still had areas that were not cleaned from the previous observation.<br><br>Observations on Unit G were as follows:<br><br>- On 1/13/2025 at 10:58 AM, room [ROOM NUMBER] had valance coming off the holder above the window, and exposed radiator tubing under the radiator.<br><br>- On 1/13/2025 at 11:46 AM, the bathroom for room [ROOM NUMBER] had no light working.<br><br>- On 1/13/2025 at 12:41 PM, the handrails throughout the unit were scuffed, nicked, and scraped, exposing the untreated wood.<br><br>During an interview on 1/14/2025 at 2:21 PM, Family Representative #2 reported there was always a smell on the unit from bags when they change people. They stated staff left the bags in the hallway and then removed them to the soiled linen room at a later time. They stated that housekeeping was less to be desired, and they did not do the proper cleaning of areas as they felt the floors were not properly cleaned.<br><br>During an interview on 1/21/2025 at 11:04 AM, Director of Housekeeping #1 stated that resident rooms were cleaned daily. They stated they did a 4/10 daily cleaning of the rooms in which they clean the high-touch areas, made sure there was no dust in the rooms, cleaned the bathroom, sweep and mopped the floors. They stated that they did a 10/10 deep clean of the room when a resident was discharged , or a resident changed room. They stated they did evaluations and inspections on rooms occasionally and kept records of what was cleaned. They stated they may have to increase the consistency of spot inspections for their staff. Currently, they stated they did not have any complaints or grievances when it came to the cleanliness of resident rooms.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/23/2025 at 9:45 AM, Director of Maintenance #1 stated the unit damage to the walls, doors, and handrails happened from residents' grabbing and scratching the rails as well as their wheelchairs or stretchers hitting it. If any damage to the walls occurs or other issues the staff need to inform maintenance so they could fix it. Director of Maintenance #1 stated they had not received any work orders related to any issues within the units. Work orders were created by staff when an issue occurred and were placed in a work order book. Maintenance would then review the books several times a day and fix any immediate issues they find. They stated that if a part needs to be ordered then the work order did not get completed. Director of Maintenance #1 stated that they did not notify residents that the order could not be completed due to a part being ordered. They stated that they were aware of the handrails but have not done anything yet to correct them. e Director of Maintenance #1 stated that the building was old. They stated that the facility was working with an outside contractor to replace all of the current lights in the building with higher-efficiency LED lighting. They stated that they had completed the main areas and hallways and were now transitioning to resident rooms which they believed would start very soon. They stated that they were aware that hot water took some time to get from the boiler to the resident's room on the far side of the building. They have instructed staff to let water run to get the hot water circulating through the system to the resident' rooms and showers in those locations. Director of Maintenance #1 stated that they were transitioning heating and air-conditioning units in the resident's rooms to newer units. If an issue regarding the units was reported, then the maintenance department would correct it by replacing the unit in the resident room. In mentioning room [ROOM NUMBER], Director of Maintenance #1 viewed the exposure of the hoses under the radiator system. They stated that the unit was smaller, and they would need to do something regarding the exposed hoses. In mentioning the exposed old radiator piping they stated that they would need to do something about that as well since these were a smaller unit.<br><br>10 New York Codes of Rules and Regulations 415.5(h)(2)<br><br>48744 |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>51317<br><br>Based on observations, interviews, and record review conducted during a recertification survey, the facility did not ensure residents had the right to voice grievances without discrimination or reprisal and without fear of discrimination or reprisal. Specifically, residents were not provided information on how to file a grievance or complaint anonymously.<br><br>This is evidenced by:<br><br>The facility Policy titled, Grievances, created 3/2016 with a current revision date of 7/02/2024, documented policy implementation included upon admission, the resident and/or resident representative are provided with information on how to file a grievance. Grievances may be submitted orally, in writing, and anonymously. Written grievances should be signed by the resident and/or representative whenever possible. The Director of Social Work is the facility's Grievance Officer and is responsible for facilitating the grievance process.<br><br>During a general observation on 1/23/2025 at 1:48 PM, there was no location for a resident or representative to put a completed grievance form if they wanted to file a grievance anonymously. There was no secured box or drop area noted in an easily accessible location for residents or representatives, such as in the front lobby of the facility, or on any of the three units throughout the facility, for anonymously completed grievance forms.<br><br>During Resident Council meeting on 1/14/2025 at 11:07 AM, that was attended by five residents, it was stated if residents wanted to file a grievance, they would go to the office and ask to speak with the administrator. Most residents at the meeting stated they had never filed an official grievance. They stated people may be afraid to speak frankly due to retaliation. They also stated it may be hard to file an anonymous complaint because it could be obvious which resident the concern was related to, and that confidentiality could be broken. The resident council president shared that some residents take their concerns to the president, and they share it with the Director of Social Work or another staff member.<br><br>During an interview on 1/21/2025 at 2:29 PM, Licensed Practical Nurse #1 was asked if there was a place, such as a box, in which a resident could submit an anonymous grievance. Licensed Practical Nurse #1 stated they did not know of a place where an anonymous grievance could be deposited. When asked what they would do if a resident came to them with a grievance, they stated they did not know what they would do and they would find the unit manager or the Director of Nursing to let them know. They stated they assumed there was some paperwork they would need to fill out.<br><br>During an interview on 1/21/2025 at 2:31 PM, Registered Nurse #1 was asked to describe the grievance process. They stated there was a form to take down the information and they would bring it to their supervisor who was the Director of Nursing. They stated they would start to think of immediate steps that should be taken for the resident or family member. Registered Nurse #1 stated there was no box on the unit for an anonymous grievance to be deposited.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/21/2025 at 2:11 PM, Director of Social Work #1 stated they were the Grievance Officer and there was a binder on each unit labeled 'grievances' with blank grievance forms. Staff could fill out the grievance form. They stated when they received the completed form, they went to the appropriate team member to discuss the grievance and come up with a resolution as a team, followed up with the resident and implemented the resolution. The grievance process procedure was outlined in the new admission paperwork provided to the residents when they were admitted to the facility. They stated there was no way to file a grievance anonymously.<br><br>During an interview on 1/22/2025 at 1:59 PM, Administrator #1 stated there were binders on each unit for filling out blank grievance reports. When asked how the residents would know about this binder, they replied there was an ad hoc meeting in December in the dining room and this was discussed. When asked about how a resident could file an anonymous grievance, Administrator #1 stated residents usually do not want their grievances to be anonymous because the Administrator would not be able to rectify it. Residents came to them with the details of their grievance, and they investigated it. Administrator #1 stated they had not been in a situation where the resident reporting the grievance wanted to be completely anonymous. When asked how a resident could file an anonymous grievance, Administrator #1 stated residents could put the completed form in their box outside their office door or could give it to someone the resident trusted and have that person slip it under the administrator's door or put it in the social worker's mailbox.<br><br>10 New York Codes, Rules, and Regulations: 415.3(d)(1)(i) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>48744<br><br>Based on observation, record review and interviews during the recertification survey, the facility did not ensure the resident's right to be free from abuse and neglect for 1 (Resident #40) of 40 residents reviewed for abuse and neglect. Specifically for Resident #40, a Certified Nurse Aide did not follow the resident's comprehensive care plan when giving personal care, during which the resident fell from their bed and sustained a broken leg on 10/01/2024.<br><br>This is evidenced by:<br><br>A policy titled, Abuse Policy, revised 12/2022, documented that the facility prohibited the mistreatment, neglect, and abuse of residents/patients and misappropriation of the resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The policy further documented that neglect was defined as failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or distress. Under Abuse - Protocol, it was documented that the Administrator and Director of Nursing were responsible for investigating and reporting. Under Abuse - Prevention, it was documented that to identify, correct, and intervene in situations where abuse, neglect, and or mistreatment were more likely to occur included but was not limited to identification/analysis of sufficient staffing on each shift to meet the needs of the residents/patients, assigned staff demonstrating knowledge of individual resident/patient needs, and sufficient and appropriate supervisory staff to identify inappropriate behaviors.<br><br>Resident #40 was admitted to the facility with the diagnoses of seizure disorder (brain condition that causes episodes of abnormal electrical activity in the brain), morbid obesity (severe form of obesity that's characterized by a high body mass index), and bipolar disorder (mental illness that causes extreme mood swings). The Minimum Data Set (an assessment tool) dated 10/16/2024, documented that the resident was able to understand others, be understood, was minimally cognitively impaired, and needed significant help with activities of daily living.<br><br>Review of the Comprehensive Care Plan for Activities of Daily Living, created 12/04/2023 and last updated 10/09/2024, documented the goal of Resident's activities of daily living status will improve through the review date. The documented interventions included that Resident #40 was dependent on 2 or more staff members and did not use their own strength to complete the following tasks:<br><br>Shower/Bathe<br><br>Roll Left and Right: Dependent x2 or more staff<br><br>Lying to Sitting on Side of Bed<br><br>Personal Hygiene<br><br>Toileting Hygiene<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Comprehensive Care Plan for mobility, created 12/01/2023 and updated 10/09/2024, documented the goal that the resident would remain free of complications related to immobility, including contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes limb stiffness and shortening), thrombus formation (a blood clot formed in a blood vessel or the heart), skin-breakdown, and falls with related injury. The documented interventions included but were not limited to, wheeling in wheelchair (resident was dependent on at least one person to physically assist them to complete the task). The resident did not use own strength for any part of the activity.<br><br>A facility incident report, dated 10/01/2024 at 6:31 PM, documented that Resident #40 had fallen out of bed while being cared for by Certified Nurse Aide #5. Resident #40 stated per the report, documented that the staff member was assisting them to roll over, the resident rolled too close to the edge of the bed and fell off it. Registered Nurse #6 was called to assess Resident #40, and the decision was made to send the resident to the hospital because the resident was complaining of pain to their leg, had struck their head, was on Eliquis (a blood thinner), and they had a laceration on their toe which was bleeding.<br><br>A hospital orthopedic (a doctor that specialized in bones and tendons) consultation note dated 10/02/2024 at 2:54 AM documented that Resident #40 had sustained a right distal femur fracture (a break in the lower part of the right thigh bone, just above the knee joint). Resident #40 did not require surgical intervention for the fracture.<br><br>During an interview on 1/13/2025 at 11:58 AM, Resident #40 stated that in October 2024, they were getting cleaned up and Certified Nurse Aide #5 rolled them over too far, and they fell out of bed and broke their leg. Resident #40 stated that Certified Nurse Aide #5 had been fired after the fall. Resident #40 stated that they did not like getting out of bed because it required a Hoyer lift and that they could not stand on their own because of their leg.<br><br>During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #4 stated that the Director of Nursing kept all incident reports and investigations in their office and reports would need to be requested directly from the Director of Nursing. Additionally, Licensed Practical Nurse #4 stated that documentation of resident incidents and complaints were never documented in Point Click Care (the electronic system used by the facility), only on the incident report sheets completed by Director of Nursing or Administrator, and they were the only authorized staff to report incidents to the Department of Health.<br><br>During an interview on 1/21/2025 at 2:02 PM, Licensed Practical Nurse #1 stated they were educated on abuse and neglect yearly. If a resident sustained a fall during care, if anything was broken, it would require reporting, and possibly call 911.<br><br>During an interview on 1/21/2025 at 2:16 PM, Registered Nurse Manager #1 stated that for falls with injuries, the Unit Manager should have been notified immediately. The Director of Nursing should have been notified immediately. Additionally, only the Director of Nursing or the Administrator reported to Department of Health, but if the Registered Nurse Manager #1 thought an incident needed to be reported and thought that no one had reported it, the Registered Nurse Manager #1 would call themselves.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that if the resident fell because of a care plan violation, the Department of Health had to be called within 2 hours. If the staff did not know how the resident got injured, that would also be a reportable incident. The employee involved would be sent home and investigation would begin. If a resident sustained an injury and the source of the injury could be explained, or if there was no violation of the care plan, no reporting would be required. Additionally, Director of Nursing #1 stated that abuse training was provided to all staff annually, when something adverse occurred, or if they felt the staff needed a refresher. Director of Nursing #1 stated that agency staff were educated on the facility's abuse policy during their orientation.<br><br>During an interview on 1/22/2025 at 1:00 PM, Administrator #1 stated that they would report all allegations of abuse in 2 hours if they were found to be substantiated. Administrator #1 also stated the regulation for reporting abuse stated that all abuse needs to be reported in 2 hours and that they would attempt to unsubstantiate the abuse allegations within two hours. Administrator #1 stated that if there were multiple witnesses to the incident, if a staff member was not working, or if there was no evidence of abuse, they would consider the allegation unsubstantiated and not report it. Administrator #1 stated that the first thing to do would be to suspend the accused staff member and then complete the investigation. They stated if they believed abuse or neglect had occurred, they would report the incident to the Department of Health within 2 hours.<br><br>10 New York Code of Rules and Regulations 483.12 (a) (1) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>48744<br><br>Based on observations, record review, and staff interviews during the recertification survey, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 resident (Resident #40) of 40 residents reviewed for abuse, neglect, exploitation, or mistreatment. Specifically for Resident #40 the facility did not report a violation of Comprehensive Care Plan requiring two care givers to provide personal care which resulted in a fall with injury.<br><br>This is evidenced by:<br><br>The facility policy titled, Abuse Policy, created 9/2012, last updated 12/2022, documented that the facility prohibited the mistreatment, neglect, and abuse of residents/patients and misappropriation of the resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The policy further documented that neglect was defined as failure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or distress. Under Abuse - Protocol, it was documented that the Administrator and Director of Nursing were responsible for investigating and reporting. Under Abuse - Prevention, it was documented that to identify, correct, and intervene in situations where abuse, neglect, and or mistreatment were more likely to occur included, but was not limited to, identification/analysis of sufficient staffing on each shift to meet the needs of the residents/patients, assigned staff demonstrating knowledge of individual resident/patient needs, and sufficient and appropriate supervisory staff to identify inappropriate behaviors.<br><br>Resident #40<br><br>Resident #40 was admitted to the facility with the diagnoses of seizure disorder (brain condition that causes episodes of abnormal electrical activity in the brain), morbid obesity (severe form of obesity that's characterized by a high body mass index), and bipolar disorder (mental illness that causes extreme mood swings). The Minimum Data Set (an assessment tool) dated 10/16/2024, documented that the resident was able to understand others, be understood, was minimally cognitively impaired, and needed significant help with activities of daily living.<br><br>Review of the Comprehensive Care Plan for Activities of Daily Living, created 12/04/2023 and last updated 10/09/2024, documented the goal of Resident's activities of daily living status will improve through the review date. The documented interventions included that Resident #40 was dependent on 2 or more staff members and did not use their own strength to complete the following tasks:<br><br>- Shower/Bathe<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Roll Left and Right: Dependent x 2 or more staff<br><br>- Lying to Sitting on Side of Bed<br><br>- Personal Hygiene<br><br>- Toileting Hygiene<br><br>Review of the Comprehensive Care Plan for mobility, created 12/01/2023?and updated 10/09/2024, documented the resident would remain free of complications related to immobility, including contractures ( permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), thrombus formation (the formation of a blood clot inside a blood vessel), skin-breakdown, and falls related injury. The documented interventions included but were not limited to, wheeling in wheelchair (resident was dependent on at least one person to physically assist them to complete the task). The resident did not use own strength for any part of the activity.<br><br>A facility incident report, dated 10/01/2024 at 6:31 PM, documented that the resident had fallen out of bed while being cared for by Certified Nurse Aide #5. Resident #40 stated per the report, that the staff member was assisting them to roll over, the resident rolled too close to the edge of the bed and fell off it. Registered Nurse #6 was called to assess Resident #40, and the decision was made to send the resident to the hospital because the resident was complaining of pain to their leg, had struck their head, was on Eliquis (a blood thinner), and they had a laceration on their toe which was bleeding.<br><br>A hospital orthopedic (a doctor that specialized in bones and tendons) consultation note dated 10/02/2024 at 2:54 AM documented that Resident #40 had sustained a right distal femur fracture (a break in the lower part of the right thigh bone, just above the knee joint). Resident #40 did not require surgical intervention for the fracture.<br><br>There was no documented evidence that the incident was reported to the Department of Health.<br><br>During an interview on 1/13/2025 at 11:58 AM, Resident #40 stated that in October they were getting cleaned up and a Certified Nurse Aide rolled them over too far and Resident #40 fell out of bed and broke their leg. Resident #40 stated that the Certified Nurse Aide #5 had been fired after the fall. Resident #40 stated that they did not like getting out of bed because it required a Hoyer lift and that they couldn't stand on their own because of their leg.<br><br>During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #4 stated that the Director of Nursing keeps all incident reports and investigations in their office. Licensed Practical Nurse #4 stated documentation of resident incidents and complaints were never documented in the medical chart. The information was included on the incident report by the Director of Nursing or the Administrator, and they were the only authorized staff to report incidents to the Department of Health.?<br><br>During an interview on 1/21/2025 at 2:02 PM, Licensed Practical Nurse #1 stated they were educated on abuse and neglect yearly. If a resident sustained a fall during care, which resulted in a broken bone, it would require reporting and possibly a call 911.<br><br>(continued on next page) |

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| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/21/2025 at 2:16 PM, Registered Nurse Manager #1 stated that for falls with injuries, the Unit Manager and the Director of Nursing should have been notified immediately. Registered Nurse Manager #1 stated that only the Director of Nursing or the Administrator reported to Department of Health, but if the Registered Nurse Manager #1 thought an incident needed to be reported and they thought that no one had reported it, the Registered Nurse Manager #1 would call themselves.<br><br>During an interview on 1/22/2025 at 12:40 PM, Director of Nursing #1 stated they had to pull up the policy for abuse and reporting to refer to it when asked about the reporting process for allegations of abuse, neglect, and misappropriation. Director of Nursing #1 stated they were responsible for investigating allegations, interviewing all staff and residents involved, and bringing the information to the Administrator. They stated the Administrator could speak to the reporting within two (2) hours requirement.?<br><br>During an interview on 1/22/2025 at 1:00 PM, Administrator #1 stated they would report all allegations of abuse within two (2) hours if they were found to be substantiated. Administrator #1 also stated the regulation for reporting abuse stated that all abuse needs to be reported within two (2) hours, and they would attempt to unsubstantiate the abuse allegations within two (2) hours. Administrator #1 stated that if there were multiple witnesses to the incident, if a staff member was not working, or if there was no evidence of abuse, they would consider the allegation unsubstantiated and not report it.<br><br>During a follow up interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated if a resident fell because of a care plan violation, the Department of Health had to be called within 2 hours. The employee involved would be sent home, and an investigation would begin. If the staff did not know how the resident got injured, that would be a reportable incident.<br><br>10 New York Code of Rules and Regulations 415.4(b)(2)<br><br>51131 |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51131<br><br>Based on interview and record review, the facility did not ensure each resident had an appropriate and safe discharge for 1(Resident #362) of 3 residents reviewed for discharge. Specifically, Resident #392 did not feel they were discharged appropriately, did not have a discharge planning meeting with Social Work and did not receive adequate discharge education or written notice of their rights to appeal the decision.<br><br>This is evidenced by:<br><br>Resident # 362 was admitted to the facility with diagnoses of fracture of one femur, repaired (broken hip repaired surgically), polysubstance abuse (drug and alcohol abuse) and unspecified osteoarthritis (arthritis of the bones and joints). The Minimum Data Set (an assessment tool) dated 1/14/2025 documented resident was cognitively intact, could be understood by and could understand others.<br><br>Policy and procedure titled, Discharge - Transfer/Discharge Process, created 11/2017 and revised 10/10/2024, documented if a resident was being discharged to the community, the Social Worker or designee in conjunction with the interdisciplinary team and healthcare provider would coordinate the necessary medical, physical, mental, and psychosocial services for the resident's safe transition to the community. The resident and/or their representative would receive written notice of the facility's intent for transfer/discharge and their appeal rights prior to the time of discharge from the facility.<br><br>A Physical Therapy Initial assessment dated [DATE], documented Resident #362 presented below baseline and would benefit from skilled Physical Therapy to increase strength, balance, endurance coordination, and safety to decrease pain and improve functional mobility. The assessment further documented Resident #362 needed to be able to climb stairs to safely return to their home in the community.<br><br>A Physical Therapy Evaluation dated 1/13/2025, documented remaining impairments were decreased and skilled Physical Therapy was required due to decreased self efficacy, impairments in multiple areas of the body and to multiple systems, need for multiple therapies, pain severity level and time since onset or acuity of the resident's injury.<br><br>Physical Therapy assessment dated [DATE] documented Resident #362 demonstrated little to no physical impairments as a result of skilled rehab and that the resident reached their maximum potential.<br><br>Record Review of Social Work discharge planning update note for Resident #362 dated 1/17/2025, documented the following:<br><br>- Social Worker #1 met with Resident #362 to discuss discharge planning.<br><br>- A 2-wheeled walker was provided.<br><br>-Referral to be made for Physical Therapy and Occupational Therapy through a Certified Home Health Agency.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Resident would be transported to their home by a family member.<br><br>- Social Work would fax a discharge notice to Primary Care Provider.<br><br>- Resident signed their discharge notification.<br><br>There was no documented evidence that education was provided to Resident #362 or if Notification of Appeal Process had been reviewed.<br><br>During an interview on 1/14/2025 at 11:13 AM, Resident # 362 stated they were admitted on [DATE]. They stated that on 1/09/2025, they were very distressed by the care they had received and requested to leave the facility for another facility. They were told by the 3 PM - 11 PM nurse that they were not allowed to leave because they had signed for admission for 20 days. Resident #362 stated they were told if they left, they would be signing out Against Medical Advice and the insurance would not pay for their stay. The 3 PM - 11 PM nurse told them that they would call an ambulance and send Resident #362 wherever they wanted to go. Resident #362 Stated they became confused when Social Worker #1 came to them on 1/13/2025 and told them they were ready to leave. Social Worker #1 told Resident #362 they needed to sign a paper for the insurance stating they agreed with leaving. Resident #362 stated no other documentation was provided. Social Worker #1 told Resident #362 if they did not want to be discharged and chose to stay after 1/17/2025, they would be responsible for private pay. Resident #362 stated they did not feel ready to leave because they needed more Physical Therapy, and they thought they were deemed independent after they had complained about their care.<br><br>During an interview on 1/23/2025 at 1:50 PM, Director of Rehabilitation #1 stated Resident #362 was very ready to go home as far as they could ascertain from the therapy documentation, but they would need to consult with the actual therapists for more details.<br><br>During an interview on 1/23/2024 at 2:04 PM Social Work Director #1 stated they had received a Notice of Discontinuation of payment from Resident #362's insurance and this was the reason for discharge prior to 20 days. During an interview 1/23/2025 at 2:04PM, Social Work Director #1 stated Resident #362 was discharged because their insurance was cut. They stated the original plan had been approved for 20 days, but they were notified the insurance would stop paying on 1/17/2025. Social Work Director #1 did not report that an appeal had been offered to Resident #362 and appeal information was not documented.<br><br>During an interview on 1/23/2025 at 2:04 PM Social Worker #1 stated they had delivered the Notice of Discharge to Resident #362 on 1/13/2025. Social Worker #1 stated Resident #362 was determined by the facility to be well enough to go home with [NAME] Home Care in place. Social Worker #1 stated they had not yet set up Home Care but planned to send a referral. They stated Resident #362 signed the discharge notice on 1/17/2025. Social Worker #1 did not report that an appeal had been offered to Resident #362 and appeal information was not documented.<br><br>During an interview on 1/21/2025 at 2:20 PM, surveyor stated that resident was discharged on [DATE]; Administrator #1 stated, 'were they?'<br><br>10 New York Code of Rules and Regulations 483.15 (c)(5) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>48615<br><br>Based on record review and interview during the recertification survey, the facility did not ensure written notice specifying the duration of the bed-hold policy, was provided to the resident and the representative at the time of transfer for hospitalization for 1 (Resident #22) of 1 resident reviewed for hospitalization . Specifically, for Resident #22, the resident and the resident's representative were not notified in writing of the bed hold policy when the resident was admitted to the hospital on 8/25/2024.<br><br>This is evidenced by:<br><br>The facility policy titled, Discharge - Transfer/Discharge Process, date created 11/2017, last revised 10/10/2024, documented the facility would coordinate a safe transfer or discharge for residents leaving the facility. When a resident is transferred or discharged from the facility, details of the transfer or discharge would be documented in the clinical record and appropriate information would be communicated to the receiving health care facility or provider. Additionally, the policy documented that if a transfer to the hospital was required for an urgent medical need or if the resident's behaviors posed a threat to their or others' safety or well-being; a resident being transferred to a hospital for an urgent medical or psychiatric need would be provided the written notice at the time of the transfer to the hospital, and their resident representative would be provided the written notice as soon as practicable thereafter; if a resident was transferred to the hospital because the facility was unable to safely manage the resident's care at the time of transfer, the facility was expected to readmit the resident once the hospital has determined it is safe for them to return to the facility unless the resident/representative has already appealed the transfer decision and it has been determined by the Department of Health that the facility is not the appropriate placement for the resident.<br><br>Resident #22<br><br>Resident #22 was admitted to the facility with a diagnosis of diabetes mellitus (A chronic metabolic disorder characterized by high blood sugar (glucose) levels), chronic obstructive pulmonary disease (inflammation inside the airways); and anxiety disorder (a type of mental health condition). The Minimum Data Set (an assessment tool) dated 12/24/2024 documented resident was cognitively intact, could be understood and understand others.<br><br>Resident #22 was transferred to the hospital on 8/25/2024 to 9/15/2024 related to respiratory distress.<br><br>There was no documented evidence that a notice of discharge or bed hold was provided to the resident or the resident's representative.<br><br>There was no documented evidence that there was a notice of discharge or bed hold in Resident #22's facility records.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 1/17/2025 at 11:41 AM, Registered Nurse #5, the nurse responsible for sending Resident #22 to the hospital, stated that on 8/25/2024, when Resident #22 went to the hospital, they notified the medical provider, notified the family, filled out the transfer sheet, was given verbal consent to send Resident #22 to the hospital, and filled out the electronic transfer sheet. Registered Nurse #5 stated that they called Resident #22's family and they had an issue with the bed hold, which they made note of but did not follow up on.<br><br>During an interview on 1/17/2025 at 11:12 AM, Director of Nursing #1 stated that when a resident required transfer to the hospital, the order of operations was to document the change in the resident's condition, call the medical provider to get an order to transfer the resident to the hospital or call 911 if needed, make a copy of the resident's Medical Orders for Life-Sustaining Treatment (MOLST) form, notify the resident's family regarding the transfer, give report to emergency services, and send the resident to the hospital with the appropriate paperwork. Director of Nursing #1 stated appropriate paperwork was described as the electronic transfer form, order summary, medical diagnosis, immunizations, resident face - sheet, resident profile information, and any new labs that were done. Director of Nursing #1 stated the staff member would be expected to call the hospital emergency room and give a report of the resident's condition and reason for sending.<br><br>10 New York Code Rules and Regulations 415.3(h)(4)(i)(a) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630<br><br>Based on record review and interviews during the recertification survey, the facility did not ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for 7 (Resident #s 6, 17, 22, 24, 40, 60, and 92) of 40 residents reviewed. Specifically, the Preadmission Screening and Resident Review (PASARR, New York State Department of Health form 695) was incomplete for Residents #s 6, 17, 22, 24, 40, 60, and 92).<br><br>This is evidenced by:<br><br>The Policy and Procedure titled, Preadmission Screening and Resident Review (PASARR)/Screens, revised 12/2019, documented the Admissions department would obtain a completed Level 1 Screen for all admissions prior to being accepted to and arriving at the facility. The Admissions department would ensure that if the Level 1 Screen required a Level II Preadmission Screening and Resident Review (PASARR) evaluation, the Level II Preadmission Screening and Resident Review (PASARR) evaluation was completed and obtained for those individuals prior to admission to the facility. Upon admission, the social worker would be responsible to ensure the completed Level 1 Screen (and Level II Preadmission Screening and Resident Review (PASARR) if required) was in the medical record. To identify if a Level II Preadmission Screening and Resident Review (PASARR) evaluation was required for a resident who had a newly diagnosed mental illness or intellectual disability, a Level 1 Screen would be completed by a qualified screener. A new Screen and a Level II Preadmission Screening and Resident Review (PASARR) evaluation (if required) would be completed within the required timeframe according to state regulations. The Director of Social Work would conduct regular audits to ensure compliance of the Screen/ Preadmission Screening and Resident Review (PASRR) process.<br><br>Resident #17:<br><br>Resident #17 was admitted to the facility with diagnoses of major depressive disorder (recurrent), Post-Traumatic Stress Disorder (a mental health condition caused by an extremely terrifying event, with symptoms that may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event), and anxiety disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>The Telepsychology Note dated 10/23/2024 at 1:10 PM, Notes documented Post-Traumatic Stress Disorder, generalized anxiety disorder, major depressive disorder; recurrent, unspecified, and anxiety disorder. The provider met with the resident, who refused to engage with the provider. The resident's behavior documented anxious, pleasant, resistant, and paranoid.<br><br>The Preadmission Screening and Resident Review for Resident #17 dated 8/31/2022, Level I Review for Possible Mental Illness (MI) (question 23 - does this person have a serious mental illness?) documented no, when the resident had a diagnosis of major depressive disorder (recurrent, moderate). Level II Referrals (questions 33 and 34) were unanswered.<br><br>There was no documented evidence of a Level II Referral for Resident #17.<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #40:<br><br>Resident #40 was admitted to the facility with diagnoses of seizure disorder (brain condition that causes episodes of abnormal electrical activity in the brain), morbid obesity (severe form of obesity that's characterized by a high body mass index), and bipolar disorder; current episode depressed, moderate (mental illness that causes extreme mood swings). The Minimum Data Set, dated dated dated [DATE], documented the resident was minimally cognitively impaired, could be understood, and understand others and needed significant help with activities of daily living.<br><br>The Preadmission Screening and Resident Review for Resident #40 dated 11/20/2020, Dementia Diagnosis (question 22), Level I Review for Possible Mental Illness (MI) (question 23), Level I Review for Possible Mental Retardation/Developmental Disability (MR/DD) (questions 24, 25, 26), and Level II Referrals (questions 33 and 34), were unanswered.<br><br>Resident #60:<br><br>Resident #60 was admitted to the facility with diagnoses of bipolar disorder, schizophrenia (a serious mental health condition that affects how people, think, feel, and behave), and unspecified dementia without behavioral disturbance. The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment. The resident usually made themselves understood and usually understand others.<br><br>The Preadmission Screening and Resident Review for Resident #60 dated 10/4/2022, Level I Review for Possible Mental Illness (MI) (question 23 - does this person have a serious mental illness?) documented no, when the resident had diagnoses of schizophrenia and bipolar disorder. Level II Referrals (questions 33 and 34) were unanswered.<br><br>There was no documented evidence of a Level II Referral for Resident #60.<br><br>During an interview on 1/16/2025 at 9:45 AM, Director of Social Work #1 stated the Preadmission Screening and Resident Review Level II form was not required for Resident #60 because they needed to qualify for all requirements on page 30-32 of the Instruction Manual for Screen form that they used. The Surveyor reviewed the document and pointed out that Resident #60 could potentially qualify for all the requirements based on their diagnoses of bipolar disorder and schizophrenia with dementia. Director of Social Worker #1 responded, That doesn't apply because they were admitted for rehab. The Director of Social Work #1 stated, I checked with my Corporate Social Worker, and they said we do not have to do it.<br><br>During an interview on 1/22/2025 at 10:41 AM, Minimum Data Set Coordinator #1 stated the Social Worker was responsible for reviewing the Preadmission Screening and Resident Review. They stated there should be a Level II evaluation whenever there was a qualifying mental illness diagnosis.<br><br>During an interview on 1/23/2025 at 9:41 AM, Corporate Registered Nurse #1 was asked to provide Level II evaluations on Resident #s 6, 17, 60, and 92. They stated the residents did not have a qualifying stay for mental illness and according to Corporate, the facility did not have to do a Level II.<br><br>10 New York Code of Rules and Regulations 415.11(e)<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 48615<br><br>48744 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413<br><br>Based on record review and interview during the recertification survey and an abbreviated survey (Case #NY00358820), the facility did not ensure the development and implementation of comprehensive person-centered care plans that included measurable objectives and timeframes to meet the resident's medical, nursing, and psychosocial needs for 7 (Resident #s 14, 27, 38, 40, 211, 362, and 364) of 40 residents reviewed. Specifically, the facility did not ensure [a.] Resident #14 had a care plan developed for diagnoses of benign prostatic hyperplasia, obstructive uropathy, tremors, generalized anxiety disorder, and constipation, [b.] Resident #27 had a care plan developed for the use of a physician prescribed hormone cream, [c.] Resident #38 had a care plan developed for diagnoses of epilepsy and seizures, [d.] Resident #40 had a care plan developed for diagnosis of constipation, [e.] Resident #211 had a care plan developed to address self-performed oral suctioning as ordered by the physician, [f.] Resident #362 had a care plan developed to address the use of thigh high stockings for deep vein thrombosis (blood clot) prevention as ordered by the physician, and [g.] Resident #364 had a care plan developed for pain management.<br><br>This is evidenced by:<br><br>Cross-referenced to: F684: Quality of Care<br><br>The Policy and Procedure titled, Care Plans-Comprehensive, revised 10/2019, documented a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The care planning process would include an assessment of the resident's strengths and needs. The comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required comprehensive Minimum Data Assessment and would include measurable objectives and timeframes, describe services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and incorporate identified problem areas, reflect currently recognized standards of practice for problem areas and conditions.<br><br>Resident #14:<br><br>Resident #14 was admitted with diagnoses of Schizophrenia (a chronic mental illness characterized by symptoms such as hallucinations, delusions, and cognitive challenges), benign prostatic hyperplasia (prostate enlargement), and obstructive and reflux uropathy (a disorder of the urinary tract). The Minimum Data Set (an assessment tool) dated 11/30/2024, documented that the resident was cognitively intact, could be understood and could understand others.<br><br>The Minimum Data Set, Quarterly assessment dated [DATE], Section I Active Diagnoses documented obstructive uropathy and benign prostatic hyperplasia with lower urinary tract symptoms.<br><br>(continued on next page) |

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| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

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| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Federally Mandated (60-day) Visit note dated 12/12/2024 by Provider #1, documented the resident received Flomax Capsule daily for benign prostatic hyperplasia, Miralax powder and Senna tablets daily for constipation, and Amantadine Capsule daily for tremors. Past medical and surgical history documented bowel resection (part of the intestine was removed). Assessment documented obstructive uropathy symptoms were controlled and generalized anxiety disorder was stable and was followed by psychiatry.<br><br>The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for diagnoses of benign prostatic hyperplasia, obstructive uropathy, tremors, generalized anxiety disorder, and constipation.<br><br>Resident #38:<br><br>Resident #38 was admitted with diagnoses of bipolar disorder (mental illness that causes extreme mood swings), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness), and epilepsy (a chronic neurological condition characterized by recurrent seizures). The Minimum Data Set, dated dated dated [DATE], documented the resident, was severely cognitively impaired, could be understood, and understand others, and was dependent with activities of daily living.<br><br>The Minimum Data Set, Quarterly assessment dated [DATE], Section I Active Diagnoses documented seizure disorder or epilepsy.<br><br>The Order Summary Report for active orders as of 7/21/2024, documented a physician order dated 4/18/2024 for Valproic Acid Oral Solution 250 milligram/5 milliliters give 15 milliliters by mouth at bedtime for seizures.<br><br>The Federally Mandated (60-day) Visit note dated 1/21/2025, documented the resident received Valproic Acid 750 milligram (used for epilepsy and bipolar disorder) daily at bedtime. The indication for use of the medication was not documented. Assessment documented bipolar disorder: currently depressed, mild, stable and was followed by psychiatry. There was no documentation about the resident's epilepsy diagnosis.<br><br>The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for diagnoses of epilepsy and seizures.<br><br>Resident #211:<br><br>Resident #211 was admitted to the facility with diagnoses of cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively), malignant neoplasm of the lip, oral cavity, and pharynx (also known as cancer, is an abnormal growth of cells that can invade and spread to other parts of the body, specific to the lip, mouth and throat), and abdominal aortic aneurysm (a bulge or enlargement in the aorta). The Minimum Data Set (an assessment tool) dated 10/10/2024, documented the resident had moderately impaired cognition. The resident was able to make themselves understood and was able to understand others.<br><br>The Order Summary Report for active orders as of 10/08/2024, documented and ordered dated 10/8/2024 for the resident to perform oral suctioning as needed every shift for excessive oral mucous.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The LN: Admission/Readmission Evaluation Part 1 dated 10/08/2024 by Registered Nurse #4, documented oral suctioning under the category of Respiratory Evaluation Concerns.<br><br>The General Documentation Note dated 10/8/2024 at 8:00 PM by Registered Nurse #4, documented proper technique and education related to oral suctioning was provided to the resident. The resident was able to demonstrate proper technique when providing oral suctioning to self and the resident was able to teach-back education received related to oral suctioning. The resident was deemed appropriate for performing oral suctioning to self without supervision. The resident was encouraged to request assistance or ask questions when needed, the resident verbalized understanding.<br><br>The Treatment Administration Record dated 10/1/2024 to 10/31/2024, documented the resident was to perform oral suctioning as needed every shift for excessive oral mucous. The treatment record was signed by the nurse as being done on 1/08/2024 during the evening shift, on 1/09/2024 during all 3 shifts, and on 1/10/2024 during the day shift.<br><br>The Minimum Data Set, dated dated dated [DATE], Section O Special Treatments, Procedures, and Programs, documented scheduled suctioning was performed while a resident and within the last 14 days.<br><br>The resident's comprehensive care plan did not include a care plan with measurable objectives and timeframes for self-performed oral suctioning.<br><br>During an interview on 1/21/2025 at 2:16 PM, Registered Nurse #1 stated that they participate care plan meetings. They would inform the social worker, providers and families of changes made to the plans of care. Additionally, Registered Nurse #1 stated that they did review comprehensive care plans but was not yet familiar with how to update them. They stated they had not been trained on how to review the care plans. Registered Nurse #1 stated that any medications that a resident take should have an International Classification of Diseases code and should be care planned for.<br><br>During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that the Registered Nurses in the building update or create care plans. Stated a Licensed Practical Nurse could put interventions in place but could not initiate a new focus. If there was a new diagnosis or medication, there should have been a new care plan focus. Stated the Registered Nurse in the building at the time of the need for a care plan initiation or change was responsible for updating the care plan.<br><br>During an interview on 1/23/2025 at 10:45 AM Director of Nursing #1 stated a resident who was permitted to self-suction would need to have a doctor's order and be assessed by nursing staff to be able to perform self-suctioning. They stated something should be in the resident's care plan for the ability to self-suction and intermittent monitoring should be done by nursing staff to ensure the resident was performing the procedure properly. They stated there should also be something in the medication and treatment administration records as well.<br><br>10 New York Code of Rules and Regulations 415.11(c)(1)<br><br>48744<br><br>51131<br><br>51317 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>34630<br><br>Based on record review and interview during the recertification and an abbreviated survey (Case #NY00364136), the facility did not ensure comprehensive care plans were reviewed and revised based on changing goals, preferences, and needs for 1 (Resident #s 6) of 40 residents reviewed. Specifically, the facility did not ensure Resident #6's comprehensive care plan was reviewed and revised when the resident fell and was assessed on 10/01/2024, 10/05/2024, 10/07/2024, 10/16/2024, 10/20/2024, 11/01/2024, 12/09/2024, and 12/11/2024.<br><br>This is evidenced by:<br><br>The Policy and Procedure titled, Care Plans-Comprehensive, revised 10/2019, documented assessments of residents were ongoing, and care plans were revised as information about the residents and the residents' conditions change. The Interdisciplinary Team reviewed and updated the care plan when there had been a significant change in the resident's condition, when the desired outcome was not met, when the resident had been readmitted to the facility from a hospital stay, and at least quarterly, with scheduled quarterly Minimum Data Sets.<br><br>Resident #6:<br><br>Resident #6 was admitted to the facility with diagnoses of muscle weakness, pain, and fall. The Minimum Data Set (an assessment tool) dated 12/20/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>Review of Incident Reports for Resident #6 dated October, November, and December 2024 documented the resident fell and was assessed with no injuries noted on 10/01/2024, 10/05/2024, 10/07/2024, 10/16/2024, 10/20/2024, 11/01/2024, 12/09/2024, and 12/11/2024.<br><br>The Care Plan for Resident had an Actual Fall related to gait/balance problems, revised 10/30/2024, did include updates following the falls documented in Incident Reports dated October, November, and December noted above.<br><br>During an interview on 1/23/2025 at 9:39 AM, Director of Nursing #1 stated that at the time of a fall the resident was immediately assessed, and interventions implemented to prevent further occurrence. They stated that the next day during the morning meeting, the resident's fall would be reviewed to ensure appropriate interventions were implemented and the resident's comprehensive care plan would be updated.<br><br>10 New York Code of Rules and Regulations 415.11(c)(2)(i-iii)<br><br>51131 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>48615<br><br>Based on observation, record review, and interviews during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 (Resident #s 22, and 75) of 40 residents reviewed. Specifically, Resident #s 22 and 75 did not consistently attend meaningful, accommodating activities to maintain their highest practicable quality of life. Additionally, Resident #22 requested supplies for an activity that was not provided.<br><br>This is evidenced by:<br><br>The facility's Policy and Procedure titled Recreation Services , last revised 5/2019, documented, The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental and psychosocial wellbeing of each resident. The activity program consists of individual, small and large group activities that are designed to meet the needs and interests of each resident and include: Activities that stimulate the cardiovascular system and assist with range of motion, such as exercise, movement to music, and physical games. Intellectual activities that are mentally stimulating, such as current events, trivia, word games, book reviews. Creative and expressive activities, such as arts and crafts, ceramics, painting, drama, creative writing, poetry and music. Social activities are scheduled to increase self-esteem, to stimulate interest and friendships, and to provide fun and enjoyment. Activities include, but are not limited to coffee socials, birthday and holiday parties, live entertainment, cultural / themed meals and events. Spiritual programming scheduled to meet the religious needs of the residents. Community outings, weather permitting. Outdoor activities, weather permitting. Residents are encouraged, but not required, to participate in scheduled activities. When a facility has a locked/secure unit, group and individual activities would be offered daily on the unit. Whenever possible, arrangements will be made to ensure that residents on the locked/secure unit are able to attend off unit activities of their choice.<br><br>Resident #22:<br><br>Resident #22 was admitted to the facility with diagnosis of diabetes mellitus, chronic obstructive pulmonary disease (inflammation inside the airways), and anxiety disorder (a type of mental health condition. Those affected may respond to certain things and situations with fear and dread). The Minimum Data Set (an assessment tool) dated 12/24/2024, documented resident was cognitively intact, could be understood and understand others.<br><br>During an interview on 01/14/2025 at 10:46 AM, Resident #22 stated they never went out of their room for an activity. They were not interested in the activities offered. Resident #22 stated they like to crochet blankets and sweaters and asked for yarn several times. They had not received the yarn. Resident #22 admitted to feeling bored often.<br><br>Resident #75:<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #75 was admitted to the facility with the diagnoses of cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to damage or death of brain cells), bipolar disorder (a mental health condition characterized by extreme and persistent mood swings), and morbid obesity (a severe form of obesity characterized by a significantly excessive body weight that poses serious health risks). The Minimum Date Set dated 10/14/2024 documented that the resident was able to understand others, be understood, was cognitively intact and required some assistance for activities of daily living.<br><br>Review of the Comprehensive Care Plan for activities initiated 1/09/2024 and last revised 8/05/2024, documented the focus of Resident #75 displayed or reported mood symptoms as evidenced by feeling depressed, decreased sleep pattern, and trouble concentrating. The goal documented that Resident #75 would verbalize an improved mood. The interventions documented included encouraging family/informal support involvement, encourage participation in activities of choice, encourage participation in activities offered, encourage resident to remain social with peers/staff, provide opportunity for resident to express self, provide support and reassurance. Resident #75's activities enjoyed were listed as TV/Adult Coloring, music (country/Doo-Wop), bingo and watching movies. Resident #75 was noted to be very social and enjoyed group activities.<br><br>Review of the Comprehensive Care Plan for Recreational activities initiated 1/24/2024 documented the focus that Resident #75 did not express an interest in recreational activities. The goal documented that Resident #75's wishes related to their recreation/leisure areas would be respected.<br><br>Review of the Comprehensive Care Plan for feelings initiated 10/15/2024 documented the focus of Resident #75 reported sometimes having feelings of loneliness and isolation from those around them. The documented goal was that Resident #75 would seek social engagement. The documented interventions included encourage participation in social events, refer to psychiatry evaluation and ongoing services as indicated, and refer for psychological evaluation and ongoing services as indicated.<br><br>A social services documentation note dated 1/09/2025 at 10:55 AM documented that Resident #75 was feeling down due to the death of their cat and enjoyed playing games on their computer. The note further documented that the social worker would continue to monitor the resident, encourage them to attend activities and encourage participation.<br><br>During an interview on 1/13/2025 at 12:43 PM, Resident #75 stated that they had to go to the dining room for activities. Mostly they were offered coloring with other residents. Resident #75 stated that they felt that it was demeaning.<br><br>During an interview on 01/21/2025 at 12:48 PM, Corporate Recreation Director #1 stated they were currently working on updating the January and February 2025 Activities calendars. They stated Activities took place 7 days per week, which was led by the Activities staff. There were a total of 4 Activities Aides, plus the Activities Director. Corporate Recreation Director #1 stated if a resident had a specific activity request, they would try to accommodate them and add to the calendar. Supplies for specific activities would be purchased. They were not aware of yarn request from Resident #22. They would place the order immediately for the yarn. Residents with dementia or unable to attend group activities were provided with 1:1 activity including books, music and food cart. Corporate Recreation Director #1 stated Activity attendance rosters along with 1:1 activity were documented manually in a binder. They were unable to provide documentation of attendance rosters and or 1:1 activities.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/21/2025 at 1:10 PM, Administrator #1 stated the Activities Director resigned without notice as of 1/13/2025. They currently have interim support from Director at Schenectady Center.<br><br>10 New York Codes, Rules, and Regulations 415.5(f)(1)h<br><br>48744 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630<br><br>Based on observation, record review, and interview during the recertification survey and an abbreviated survey (Case #NY00358820), the facility did not ensure residents receive treatment and care in accordance with professional standards of practice for 2 (Resident #s 34 and 211) of 40 residents reviewed for. Specifically, [a.] Resident #34 did not receive daily dressing changes per physician order, and [b.] the physician ordered for Resident #211 to self-perform oral suctioning as needed every shift for excessive oral mucous, however, facility policy for oral suctioning did not include a procedure and/or guidelines for self-performed oral suctioning, [c.] there was no documented evidence that Resident #211's vital signs were monitored and respiratory status assessed in accordance with professional standards of practice when the resident self-performed oral suctioning on 10/08/2024, 10/09/2024, and 10/10/2024.<br><br>This is evidenced by:<br><br>Cross-referenced to: F656: Develop/Implement Comprehensive Care Plan<br><br>Cross-referenced to: F842: Resident Records - Identifiable Information<br><br>Resident #34:<br><br>Resident #34 was admitted to the facility with diagnoses of disruption or dehiscence (splitting open) of internal surgical wound of abdominal wall muscle, surgical aftercare, and personal history of malignant neoplasm (cancer) of the large intestine. The Minimum Data Set (an assessment tool) dated 1/2/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>The policy and procedure titled, Wound Identification and Wound Rounds, revised 11/6/2023, documented the facility would identify, assess, and manage residents with pressure injuries, skin alterations, impairments, or wounds in accordance with current standards of practice.<br><br>Record review of Resident #34's care plan section titled, Care Plan for Resident has Impaired Skin Integrity related to surgical abdomen, revised 1/9/2025, documented an intervention to apply treatment per physician order.<br><br>During an observation on 1/13/2025 at 1:53 PM, Resident #34's abdominal dressing was noted with dry, brown-colored drainage and was dated 1/11/2025. Resident #34 stated they had abdominal surgery and had stitches. Stated that when they were in the previous rehabilitation facility, the wound opened, and they had to close it. Resident #34 stated they did not feel facility nursing staff was monitoring their incision and abdomen the way it should be.<br><br>Record review of, Order Recap Report, dated 12/01/2024 to 1/31/2025, documented an order dated 12/23/2024 to cleanse abdominal wound with normal saline wet; pat dry with clean gauze; apply saline wet-to-moist gauze to wound bed; cover with abdominal pad; secure with dressing retention tape; every evening shift for wound care.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Treatment Administration Record dated January 2025, documented the resident's abdominal wound treatment was administered by Licensed Practical Nurse #8 on 1/12/2025.<br><br>During an observation of Resident 34's dressing change on 1/21/2025 at 12:39 PM, Resident #34's abdominal dressing was dated 1/20/2025. When asked about daily dressing changes, the resident stated staff have forgotten to change the dressing 3 or 4 times. The resident stated they had never refused a dressing change. Resident #34 stated there was a time when they reminded a male nurse on the evening shift that the dressing needed to get changed and the nurse said they were busy doing other things. Resident #34 stated the dressing did not get changed that evening. Resident #34 stated the male nurse was busy with this unit and had to run to the B/C unit. Resident #34 stated somebody reported the nurse about the dressing not being changed. Resident #34 stated that they wanted to report to the supervisor that their dressing was not being changed and a staff member (unknown) told them no, they would just change the dressing.<br><br>During an interview on 1/23/2025 at 8:53 AM, Registered Nurse #2 stated they were not aware that Licensed Practical Nurse #8 had signed the Treatment Administration Record on 1/12/2025, but did not do the treatment. They stated they were not aware the resident had a concern about their dressing changes not being done. They stated the only time they knew the dressing was changed was on Monday 1/20/2025, during wound rounds.<br><br>During an interview on 1/23/2025 at 9:39 AM, Director of Nursing #1 stated that the minute they found out the dressing was not changed on 1/12/2025, Licensed Practical Nurse #8 was written up and received a final warning. They stated Licensed Practical Nurse #8 documented the treatment was done on 1/12/2025, but did not change the dressing.<br><br>During an interview on 1/23/2025 at 10:57 AM, Licensed Practical Nurse #8 stated that on 1/12/2025, there was a patient that needed to be sent to the hospital, and they were called off the unit. They stated they did click it as being done before it was done, and their intention was to go back in the room and change the dressing.<br><br>Resident #211:<br><br>Resident #211 was admitted to the facility with diagnoses of cardiomyopathy (a group of heart muscle diseases that weaken the heart's ability to pump blood effectively), malignant neoplasm of the lip, oral cavity, and pharynx (also known as cancer, is an abnormal growth of cells that can invade and spread to other parts of the body, specific to the lip, mouth and throat), and abdominal aortic aneurysm (a bulge or enlargement in the aorta). The Minimum Data Set, dated dated dated [DATE], documented the resident had moderately impaired cognition. The resident was able to make themselves understood and was able to understand others.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Policy and Procedure titled, Suctioning - Oral Pharyngeal, revised 1/2020, documented the purpose of the procedure was to clear the upper airway of mucous and prevent the development of respiratory distress. Preparation for the procedure documented to obtain baseline vital signs from the resident's medical record. General guidelines documented to monitor the resident's vital signs during the procedure and discontinue and notify physician if resident showed signs of distress. Assessment documented to assess for the following signs and symptoms of respiratory distress: dyspnea (difficulty breathing or shortness of breath), gurgling or rattling breath sounds, cyanosis (a bluish color in the skin, lips, and nail beds caused by a shortage of oxygen in the blood), decreased oxygen level, restlessness, and/or obvious secretions or vomitus in the mouth. Steps in the Procedure documented to assess the respiratory status of the resident and effectiveness of the procedure.<br><br>The facility's policy did not include a procedure and/or guidelines for self-performed oral suctioning by a resident.<br><br>Record review of the Order Summary Report for active orders as of 10/8/2024, documented an order dated 10/08/2024 for the resident to perform oral suctioning as needed every shift for excessive oral mucous.<br><br>Record review of the Treatment Administration Record dated 10/01/2024 to 10/31/2024, documented the resident was to perform oral suctioning as needed every shift for excessive oral mucous. The treatment record was signed by the nurse as being done on 10/08/2024 during the night shift, on 10/09/2024 during all 3 shifts, and on 10/10/2024 during the day shift.<br><br>There was no documented evidence on the Treatment Administration Record or Nursing Progress Notes that the resident's vital signs were monitored and respiratory status assessed in accordance with professional standards of practice when the resident self-performed oral suctioning on 10/08/2024, 10/09/2024, and 10/10/2024.<br><br>During an interview on 1/23/2025 at 10:45 AM, Director of Nursing #1 stated a resident who was permitted to self-suction would need to have a doctor's order and be assessed by nursing staff to be able to perform self-suctioning. They stated something should be in the resident's care plan for the ability to self-suction and intermittent monitoring should be done by nursing staff to ensure the resident was performing the procedure properly. They stated there should also be something in the medication and treatment administration records as well.<br><br>10 New York Code of Rules and Regulations 415.12<br><br>48615<br><br>51131 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>51317<br><br>Based on observation, record review and interviews during a recertification survey, the facility did not ensure each resident had an environment that was as free of accident hazards as was possible to prevent accidents for 1 (Resident #13) of 1 resident reviewed for accident hazards. Specifically, Resident #13 who shared a room with another resident was observed with medications in their room not supervised.<br><br>This is evidenced by:<br><br>Resident #13 was admitted to the facility with diagnoses of acute and chronic respiratory failure with hypoxia (when the body cannot exchange oxygen and carbon dioxide), type 2 diabetes mellitus without complications, and chronic obstructive pulmonary disease with (acute) exacerbation. The Minimum Data Set (an assessment tool) dated 11/12/2024 documented the resident was cognitively intact, could be understood and understand others.<br><br>The Policy titled, Medication-Storage created 02/2014 last revised 01/2019 documented, The center would have Medications stored in a manner that maintained the integrity of the product, ensures the safety of the residents, and is in accordance with Department of Health guidelines. Procedures included that all medications will be stored in a locked cabinet, cart, or medication room that is accessible only to authorized personnel, as defined by facility policy.<br><br>The Policy titled, Medication, Self- Administration created 03/2018 last revised 07/2019 documented Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. Storage should be in a locked box in the resident's drawer and if safe storage is not possible in the resident's room, medications of residents permitted to self-administer would be stored on a central medication cart or in the medication room.<br><br>During an observation on 01/13/2025 at 11:56 AM, an Albuterol inhaler (a prescription medication used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease) was noted to be present on the bedside table of Resident #13. Resident #13 was in a double occupancy room, with a roommate present in the other bed in the same room as Resident #13. The Albuterol inhaler was not stored in a safe and secure place, and was accessible to Resident #13 and to other residents.<br><br>During an observation on 01/15/2025 at 10:25 AM, an Albuterol inhaler (as described above) and a Trelegy inhaler (a prescription inhaler used to treat asthma and chronic obstructive pulmonary disease) was noted to be present on the bedside table of Resident #13. Resident #13 was in a double occupancy room with a roommate present in the other bed in the same room as Resident #13. The Albuterol inhaler and the Trelegy inhaler were not stored in a safe and secure place, and they were accessible to Resident #13 and other residents.<br><br>(continued on next page) |

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| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

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| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/15/2025 at 10:25 AM, Resident #13 stated the nurses left the inhalers on their bedside table throughout the day and at the end of the day after the last time it was used, they stored it on the cart. They stated in the next morning, sometimes the nurses would leave the inhalers on their bedside table, or they may store them on the medication cart.<br><br>During an interview on 01/21/2025 at 10:12 AM, Director of Nursing #1 stated there was no resident in the building that administered their own medications. They stated if a resident was not capable to administer their own medications independently but could do so with supervision, residents should not have access to the medications until it was provided by nursing.<br><br>10 New York Codes, Rules, and Regulations: 415.12 (h)(2) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744<br><br>Based on observations, record review and staff interviews during the recertification survey, the facility did not ensure that it maintained acceptable parameters of nutritional status, maintain usual body weight or desirable body weight range and electrolyte balance related to resident preferences for ordered diet; and maintain the physician ordered therapeutic diet, and offered sufficient fluid intake to maintain proper hydration and health for 2 (Resident #s 51, and 364) of 40 reviewed. Specifically, for (a.) Resident #51 the facility did not ensure that the resident was tolerating tube feedings without symptoms or nausea or vomiting, monitoring the resident's weights for significant changes, or addressing the significant weight change; for (b.) Resident #56, the physician did not order an end stage renal, diabetic therapeutic diet, the dietary department and physician did not coordinate their services to make required adjustments to therapeutic diet, based on resident lab values; and dieticians did not respect resident's choices and preferences regarding food types resulting in weight loss, poor nutrition, and psychological distress; for (c.) Resident #364, did not receive extra beverages as ordered to maintain a healthy hydration status.<br><br>This is evidenced by:<br><br>Resident #51:<br><br>Resident #51 was admitted with the diagnoses of gastrostomy malfunction (complications of a gastrostomy tube), dysphagia (difficulty swallowing), and protein-calorie malnutrition (when a protein in unable to function properly). The Minimum Data Set, dated dated dated [DATE] documented that the resident was sometimes able to understand others, sometimes able to be understood, was severely cognitively impaired and required extensive assistance with activities of daily living.<br><br>The American Society for Parenteral and Enteral Nutrition Journal of Parenteral and Enteral Nutrition Volume 41 dated January 2017, documented that anthropometry (the scientific study of the measurements and proportions of the human body), including weight and weight history, was assessed to identify an adequate and appropriate feeding regimen and to determine the presence or risk of malnutrition. Additionally, important elements of the enteral nutrition recommendation made by the nutrition clinician address the monitoring of biochemical data, anthropometrics, nutrient needs, enteral access, and enteral nutrition tolerance. Communication and implementation of the enteral nutrition recommendations were essential for successful nutrition intervention and may impact outcomes in terms of desired weight gain, and improved markers of nutrition status.<br><br>The facility's policy, Enteral Nutrition, date last reviewed 6/2023, documented that the facility would provide dietary-nursing nutritional support to residents unable to obtain nourishment orally, and were receiving enteral feeding ordered by a physician and not clinically contraindicated. The policy further documented that a Registered Dietitian would assess residents who were receiving enteral feedings and make appropriate recommendations for intervention to enhance tolerance and nutritional adequacy of enteral feedings. Additionally, the policy documented that the Registered Dietitian would recommend bolus fluid flushes with consideration of fluid content of feeding product, resident weight, diagnosis, and fluid, electrolyte and nutritional status.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Comprehensive Care Plan for tube feeding, date created 1/13/2023 and initiated 2/20/2023, documented the goals of tolerating tube feed, receive adequate nutrition and hydration without any unplanned significant weight changes, and achieve gradual weight gain towards healthy body mass index range. The interventions listed included, but were not limited to, follow weights as ordered and report significant weight changes to the medical director and interdisciplinary care team for input.<br><br>Review of the comprehensive care plan for gastrointestinal function, date created 1/13/2023 and initiated 2/20/2023, documented the goal of resident would be free of signs and symptoms of gastrointestinal upset, nausea, vomiting, and internal bleeding. The interventions documented included, but were not limited to, monitoring for signs and symptoms, and or complaints of gastrointestinal upset, nausea vomiting, distension, internal bleeding, and notify the medical director of abnormal findings.<br><br>Review of the comprehensive care plan for tube feeding related to dysphagia (difficulty swallowing) secondarily to subarachnoid hemorrhage (brain bleed), date initiated 2/20/2023, documented that the resident would be free of side effects or complications related to tube feeding, the resident's insertion site would be free of signs and symptoms of infection, and the resident would maintain adequate nutritional and hydration status as evidenced by weight stable, and no signs and symptoms of malnutrition or dehydration. The interventions listed included, but were not limited to, monitor/document/report to medical director as needed: abnormal lab values, abdominal pain, distention, tenderness, nausea and vomiting or dehydration.<br><br>On 8/06/2024 at 2:00 PM, Resident #51's weight was documented at 97.2 pounds.<br><br>On 9/11/2024 at 8:18 AM, Resident #51's weight was documented at 97 pounds.<br><br>On 10/07/2024 at 5:07 PM, Resident #51's weight was documented at 134.6 pounds.<br><br>On 11/14/2024 at 10:37 AM, Resident #51's weight was documented at 132.4 pounds.<br><br>On 12/06/2024 at 1:44 PM, Resident #51's weight was documented at 128 pounds.<br><br>A doctor's order on 12/01/2024 at 7:00 AM documented weigh on admission/readmission x 1, then weekly x 4, then monthly starting on the 1st for 1 day. Monthly weights must be obtained by the 7th of each month. There was no documented evidence of weekly weights.<br><br>A dietary note, dated 7/20/2024, did not document any issue with Resident #51's tube feed.<br><br>A dietary note dated 11/07/2024 at 1:57 PM, documented Resident #51 had a vomiting episode. Resident #51 was noted to have had significant weight gain and vomiting episodes, suspected too much tube feeding. Would keep resident on weekly weights for close monitoring and monitor tube feed tolerance.<br><br>A follow up provider notes, dated 11/08/2024, documented that Resident #51 vomited after tube feeds on 11/07/2024 and was to have tube feed adjusted.<br><br>An acute provider notes, dated 11/21/2024, documented that Resident #51 had vomited twice on the overnight shift and had loose bowel movements.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A 30 day follow up provider note, dated 11/27/2024, documented Resident #51's weight was 102.4 pounds, and that Resident #51 had been unremarkable except for multiple episodes of abdominal pain which were relieved by increasing bowel regimen.<br><br>A dietary note, dated 11/27/2024 at 2:36 PM, documented that Resident #51 was to see a gastrointestinal doctor on 1/28/2025.<br><br>During an interview on 1/16/2025 at 11:05 AM, Dietitian #1 stated that they had seen the weight fluctuation. Dietitian #1 stated that they had spoken with nursing staff at the time and asked for a weight in December that was not done. Dietitian #1 stated they would speak with staff again and explain the importance of the weights. Additionally, Dietitian #1 stated they had spoken with the unit manager on 1/15/2025 and was told that staff would do the weight for Resident #51 on that day. Noting that it was still not done at the time of the interview, Dietitian #1 stated that they would speak with the staff more forcefully about it. Dietitian #1 stated that the Director of Nursing got the weight sheets and was supposed to follow up with the staff when they were not doing what they were supposed to.<br><br>On 1/16/2025 at 11:30 AM, Dietitian #1 was observed on the unit in front of Resident #51's room asking a staff member to get the weight.<br><br>During an interview on 1/21/2025 at 2:02 PM, Licensed Practical Nurse #1 stated that they did not have time to review the resident's weights.<br><br>During an interview on 1/21/2025 at 2:16 PM, Nurse Manager #1 stated that weights should get done, but they did not always get to them done. Certified Nurse Aides could not enter weights, however there was more of a problem with Certified Nurse Aides not doing them. They stated if they saw something off regarding a resident's weight, they would send nutritionist an email. Nurse Manager stated that most of the time the process was reversed, and nutritionist would come to the nurse manager. Nurse Manager #1 stated there was not enough staff to give everyone the ability to do their job effectively.<br><br>Resident #364<br><br>Resident #364 was admitted to the facility with diagnoses of unspecified fall, influenza virus A, and other acidosis (a condition where the body has too much acid in body fluids). A Minimum Data Set, dated dated dated [DATE] documented Resident #364 was alert and oriented and cognition was intact. Resident could be understood and understand others.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A facility policy titled, Hydration, created 10/2015 and revised on 1/24/2024, documented residents would receive sufficient fluid intake that was consistent with their individual needs and preferences to maintain proper hydration and health. Calculation of the resident fluid needs would follow current standards of practice. Based on an Interdisciplinary Team review and subsequent plan of care development, the dietitian or designee would evaluate and calculate the resident fluid needs and preferences during the initial assessment, and as needed. Fluids needs would be calculated according to the resident individual needs; and the provision of fluids would be based on the resident individual preferences. The Interdisciplinary Team would routinely review the resident's fluid intake. If concerns were observed regarding the resident intake or hydration status, the resident's plan of care might be revised if indicated and the nurse would notify the healthcare provider for changes in orders as appropriate.<br><br>During an observation on 1/15/2025 at 5:30 PM, Resident #364 was observed sitting at the bedside. Resident #364 had dry, flaky skin with a slight yellow tinge. Resident #364 was observed to have dry mucous membranes in their mouth and dry lachrymal (small bone forming part of the eye socket) area around the eyes.<br><br>Record review of Care Plan titled, potential for compromised nutritional status, dated 1/08/2025 and updated 1/15/2025, documented the goals of receive adequate nutrition and hydration without any unplanned significant weight changes; and tolerate and accept modified diet texture and consistency. Interventions documented included: follow weights as ordered; monitor labs as available; review meal/ fluid consumption records; dining: (fluid ranges); fluid intake every shift (DO NOT include fluid with meals); and a bedtime snack.<br><br>Record review of a Kardex dated 1/17/2025, documented under Eating/Nutrition: Record fluid intake every shift (DO NOT include fluid with meals).<br><br>The Certified Nurse Aide task sheet did not document fluid monitoring on 1/08/2025 (11 AM-7 PM), 1/09/2025 through 1/14/2025 (all shifts), 1/15/2025 (7 AM - 3 PM), 1/17/2025 (11 PM - 7 AM), and 1/18/2025 and forward for all shifts.<br><br>A Mini-Nutritional assessment dated [DATE] at 1:56 PM, documented Resident #364 had not had a decrease in food intake in the past 3 months, had not had weight loss, had suffered psychological trauma or acute disease in the past three months, and had a recorded Body Mass Index of 23 or greater, a weight of 195.6 pounds in their wheelchair, and a height of 69.5 using the ulnar method. The assessment did not address fluid status, or hydration.<br><br>A comprehensive dietary assessment, dated 1/15/2024 at 1:57 PM, documented Resident #56's average oral intake was 75-100% of food, and 240-300+milliliters fluid per meal. Resident had a potential for weight fluctuation due to diuretic use. Resident requested to take salt packet off tray and remove high sodium foods. Would recommend changing diet to no salt products per request. Labs on 1/10/2025 showed elevated blood urea nitrogen 27 with diuretic use, other pertinent labs within normal limits. Dietary Technician #1 also documented Resident #364 had requested milk, ginger ale, and cranberry juice with their meals.<br><br>Record review of weights and vital signs, dated 1/08/2025 and 1/16/2025, documented an initial weight of 195.6 pounds, and a subsequent weekly weight of 193.6 pounds, which indicated a 2-pound weight loss in 8 days.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of laboratory blood work, dated 1/16/2025, documented a blood urea nitrogen level of 27 milligrams per deciliter, an abnormal high value.<br><br>The Comprehensive Care Plan and Kardex did not indicate the amount of extra fluids Resident #364 required each shift.<br><br>During an interview on 1/15/2025 at 5:30 PM, Resident #364 stated they had asked for water at 1 PM. Resident #364 asked a Certified Nurse Aide, and they never came back. Resident #364 reported a second Certified Nurse Aide checked on them at 4:30 PM and Resident #364 asked for 2 glasses of ice water because they did not want to be forgotten again. Resident #364 stated they received both glasses after they had waited another 20 minutes and planned to save the second glass to drink before bed. Resident # 364 reported that unless a Certified Nurse Aide opened their door to check on them, they did not receive any fluids, except for an early morning fluid pass with ice water and one drink on their meal tray. Resident #364 reported they never received extra fluids unless they asked multiple times for them.<br><br>During an interview on 1/15/2025 at 6:00 PM, Certified Nurse Aide #1 stated the residents were always thirsty and they tried to bring them ice water all day long. Certified Nurse Aide #1 reported they were not aware of special amounts of extra fluids required for any residents, or specifically for Resident #364. Certified Nurse Aide #1 reported fluids were not usually brought to residents unless they asked for more. Certified Nurse Aide #1 reported there were usually one or two drinks included with the resident's meal tray.<br><br>During an interview on 1/15/2025 at 6:15 PM, Certified Nurse Aide #4 reported they had checked on Resident #364 that evening and retrieved two plastic cups of ice water for them. Certified Nurse Aide #4 reported the did not expect that Resident #364 would ask for fluids again.<br><br>During an interview on 1/21/2025, Licensed Practical Nurse # 4 stated the residents were offered fluids, usually a cup of ice water, at the beginning of the day around 7:00 AM. Licensed Practical Nurse #4 reported any resident could request fluids at any time. Licensed Practical Nurse #4 reported they were unaware of any specific fluid needs for Resident #364.<br><br>During an interview on 1/23/2025 at 11:10 AM, Dietary Director #1 stated snacks and nourishments were delivered to the units every night. Dietary Director #1 stated the comprehensive nutritional assessment identified the required calorie and fluid amounts for each resident and were updated based on laboratory blood work and weights. Dietary Director #1 stated the Certified Nurse Aides on the unit were responsible to provide extra fluids which supplemented fluids received with meal trays. Dietary Director #1 stated the amount of fluids needed should have been on the care plan.<br><br>During an interview on 1/23/2025 at 8:44 AM, Director of Nursing stated that if there was a problem with resident's food or weight that the staff would bring it up the ladder to their attention.<br><br>10 New York Code Rules and Regulations 415.12(j)<br><br>51131 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615<br><br>Based on observations, record review, and interviews during the Recertification Survey, the facility did not ensure that residents who required respiratory care were provided such care in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident goals and preferences for 2 (Resident #'s 13 and 22) of 40 residents reviewed. Specifically, Resident #s 13 and 22 oxygen therapy were not administered as ordered by the physician.<br><br>This is evidenced by:<br><br>The Policy and Procedure titled Oxygen Therapy, last revised 09/2022, documented the administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions. However, oxygen should be regarded as a drug and therefore requires prescribing in all but emergency situations.<br><br>Failure to administer oxygen appropriately could result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring was an integral component of the Healthcare Professional's role. Oxygen is administered according to physician order. Oxygen is delivered by wall oxygen, oxygen tank (stationary or portable) or concentrator. Method used depends on the resident need and concentration required and facility capabilities. Residents who use oxygen would be monitored throughout their shift by the unit nurse to determine effectiveness of the treatment. Oxygen use would be documented on the Electronic Medical Records (EMAR) or Electronic Treatment Record (ETAR). Flow rate must be adjusted by a Licensed Nurse.<br><br>Resident #13 was admitted to the facility with diagnoses of acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues) , type 2 diabetes mellitus without complications (a problem in the way the body regulates and uses sugar as a fuel), and chronic obstructive pulmonary disease with (acute) exacerbation (a condition caused by damage to the airways or other parts of the lung, with sudden flare ups). The Minimum Data Set (an assessment tool) dated 11/12/2024 documented the resident was cognitively intact. The resident had the ability to make themselves understood and had the ability to understand others.<br><br>The Comprehensive Care Plan focus Alteration in Respiratory system related to chronic obstructive pulmonary disease dated 7/07/2023, documented resident is oxygen dependent secondary to chronic respiratory failure, emphysema and pneumonia. Goals include: Resident would receive effective treatments as evidenced by no shortness of breath or bronco spasm through the review date. Interventions: Provide oxygen per medical doctor orders. Maintain/change tubing per protocol and observe vital signs as ordered by medical doctor and report those not within normal limits.<br><br>During an observation on 01/13/2025 at 11:55 AM and on 01/15/2025 at 11:41 AM, Resident #13 was awake in their bed. The resident had oxygen via nasal cannula with a portable oxygen concentrator which was set to a liter flow of 2.5 liters per minute.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation and interview on 11/17/2025 at 10:27 AM, Licensed Practical Nurse #8 stated the computer indicated Resident #13's oxygen should be 3 liters per minute. If it was not set for 3 liters per minute, they would readjust it to the correct level. Licensed Practical Nurse #8 was asked to check Resident #13's oxygen level. Licensed Practical Nurse #8 noted the oxygen level was not set to 3 liters per minute, and they adjusted the level to 3 liters per minute. Licensed Practical Nurse #8 stated they did not know how often the oxygen level was checked to ensure it was set at the correct level.<br><br>A Physician Order dated 07/26/2024 documented supplemental oxygen via nasal Cannula at 3 liters per minute to maintain oxygen saturation greater than 88%. Every shift check oxygen saturation every shift.<br><br>The Weights and Vitals Summary indicating oxygen saturation levels for Resident #13 had the following dates and times marked for when Resident #13's oxygen saturation levels were checked for dates 01/10/2025 through 01/20/2025.<br><br>01/20/2025- checked at 12:32 AM, 8:29 AM, 4:13 PM<br><br>01/19/2025- checked at 5:06 AM, 7:38 AM, 3:55 PM<br><br>01/18/2025- checked at 9:20 AM, 4:09 PM<br><br>01/17/2025- checked at 8:24 AM, 4:14 PM<br><br>01/16/2025- checked at 12:06 AM, 10:57 AM, 3:59 PM<br><br>01/15/2025- checked at 1:23 PM, 4:10 PM<br><br>01/14/2025- checked at 7:46 AM, 4:06 PM<br><br>01/13/2025- checked at 1:55 PM, 3:44 PM, 8:21 PM<br><br>01/12/2025- checked at 8:19 AM, 4:53 PM<br><br>01/11/2025- checked at 4:43 AM, 8:35 AM, 3:18 PM<br><br>01/10/2025- checked at 4:39PM<br><br>Oxygen saturation levels were not checked each shift on 01/10/2025, 01/12/2025, 01/14/2025, 01/15/2025, 01/17/2025, 01/18/2025.<br><br>During an interview on 11/16/2025 at 11:04 AM, Licensed Practical Nurse #1 stated Licensed Practical Nurses and Registered Nurses check oxygen levels, oxygen saturations, and adjust the flow of oxygen. They indicated the Medex (a medication administration record) reminded them the levels and tank should be checked every shift.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/16/2025 at 11:12 AM, Registered Nurse #1 stated there was a prompt on the medication administration record or the treatment administration record which cued the nursing staff to check the oxygen levels for residents who received oxygen therapy. They stated the medication nurses were responsible for that task, but when they were doing rounds in the hall, they would check the oxygen levels if needed.<br><br>Resident #22 was admitted to the facility with diagnoses of diabetes mellitus (a disease that affect how the body uses blood sugar (glucose), chronic obstructive pulmonary disease (inflammation inside the airways); and anxiety disorder (a type of mental health condition. Those affected may respond to certain things and situations with fear and dread). The Minimum Data Set, dated dated dated [DATE], documented resident was cognitively intact, could be understood, and could understand others.<br><br>During an observation on 01/14/2025 11:09 AM, Resident #22 was noted to have oxygen in place via nasal cannula. Oxygen concentrator was set at 3 liters per minute.<br><br>During an observation on 01/17/2025 at 12:00 PM, Resident #22 attended physical therapy in the facility gym. Resident was noted to have oxygen in place via nasal cannula. Oxygen tank was set at 3 liters per minute.<br><br>The Medication Administration Record effective 12/30/2024 documented apply supplemental oxygen via nasal cannula at 2 liters per minute to maintain an oxygen saturation greater than 88%, every shift for respiratory failure. Measure oxygen saturation every shift.<br><br>During an interview on 01/17/2025 at 12:00 PM, Physical Therapy Aide #1 stated they noted Resident #22's concentrator was set at 3 liters per minute and switched resident over to a tank at 3 liters per minute prior to transporting resident to therapy. They also stated they asked resident how much oxygen they were using, and resident told them they were on 3 liters per minute.<br><br>During an interview on 01/17/2025 at 12:00 PM, Resident #22 stated they had always been on 3 liters per minute, even prior to hospitalization last October.<br><br>During an interview on 01/17/2025 at 12:00 PM, Licensed Practical Nurse #9 assessed resident #22's oxygen tank and noted it was set at 3 liters per minute. They then reviewed the medication administration record and noted oxygen order for 2 liters per minute. Licensed Practical Nurse #9 stated the oxygen should be set at 2 liters per minute as ordered. They stated only Licensed Practical Nursing and Registered Nursing staff were to apply oxygen. Oxygen was assessed every shift. Licensed Practical Nurse #9 stated Resident #22 did not self-administer oxygen.<br><br>During an interview on 01/17/2025 at 12:20 PM, Director of Rehabilitation #1 stated oxygen was to be applied by nursing staff. They stated they would follow up with Physical Therapy Aide #1.<br><br>During an interview on 01/22/2025 at 1:45 PM, Director of Nursing #1 stated the physician's orders included how many liters oxygen should be set. Nurses marked on the medication administration record when oxygen saturation was checked, and their signature indicated that it was checked. They stated they expected to see that it was checked every shift and there were three shifts each day.<br><br>10 New York Codes, Rules, and Regulations 415.12 (k)(6)<br><br>(continued on next page) |

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|---|---|---|---|
| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 51317 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744<br><br>Based on observation, record review, and interviews during a recertification and abbreviated survey (Case #s NY00358820 and NY00359065), 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, the facility's staffing minimum staffing levels were not met each day from 1/12/2025 through 1/17/2025 per facility assessment and New York State Nursing Home Minimum Staffing and Direct Resident Care.<br><br>This is evidenced by:<br><br>Upon entrance to the facility on [DATE] there were 118 residents residing on 3 units.<br><br>Nursing Homes are required by New York State Public Health Law and Regulations to meet minimum staffing standards. These minimum standards required every nursing home to maintain daily staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, licensed practical nurse, or registered nurse. Of the 3.5 hours required, at least 2.2 hours of care per resident per day must be provided by a certified nurse aide and at least 1.1 hours of care per resident per day must be provided by a licensed nurse.<br><br>The facility assessment dated ,d+[DATE] documented that the staffing plan was based on the resident population and their needs for care and support. The staffing plan documented the following daily staffing needs:<br><br>**<br><br>Shift, Category of Staff, Number of Staff, Total Hours Worked<br><br>Days, Registered Nurse, 1-4, 7.5-30<br><br>Days, Licensed Practical Nurse, 3-6, 22.5-45<br><br>Days, Certified Nurse Aide, 6-14, 45-105<br><br>Evenings, Registered Nurse, 0-1, 0-7.5<br><br>Evenings, Licensed Practical Nurse, 3-6, 22.5-45<br><br>Evenings, Certified Nurse Aide, 6-12, 45-90<br><br>Nights, Registered Nurse, 0-1, 0-7.5<br><br>Nights, Licensed Practical Nurse, 2-3, 15-22.5<br><br>Nights, Certified Nurse Aide, 3-8, 22.5-60<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | [Note: Where Days = 7 AM to 3 PM, Evenings = 3 PM to 11 PM, Nights = 11 PM to 7 AM]<br><br>**<br><br>A review of staffing sheets provided by the facility from 12/01/2024 through 1/11/2025 documented the following:<br><br>Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 12/07/2024, 12/14/2024, 12/28/2024, 12/31/2024, and 1/05/2025.<br><br>On 12/07/2024, the facility census was 118. There were 15 licensed nurses (Licensed Practical Nurses and Registered Nurses) scheduled to work on that day. The required hours of licensed care for the facility were 129.8 hours based on the census. The licensed staff scheduled accounted for 120 hours of care.<br><br>On 12/14/2024, the facility census was 119. There were 16 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 130.9 hours based on the census. The licensed staff scheduled accounted for 128 hours of care.<br><br>A review of staffing sheets provided by the facility from 1/12/2024 through 1/17/2025 documented the following:<br><br>Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 1/12/2025 and 1/17/2025.<br><br>To fulfill the staffing requirement for licensed nursing care (Registered Nurses and Licensed Practical Nurses) per resident per day, a facility with a census of 118 would need to schedule at least 17 staff members with nursing licenses for the entire day.<br><br>**<br><br>Date, Facility Census, Scheduled Staff, Actual Scheduled Hours, Required Staffing Hours<br><br>01/12/2025 ,118 ,10 ,80 ,129.8<br><br>01/13/2025 ,118 ,17 ,136 ,129.8<br><br>01/14/2025 ,118 ,18 ,144 ,129.8<br><br>01/15/2025 ,118 ,19 ,152 ,129.8<br><br>01/16/2025 ,118 ,19 ,152 ,129.8<br><br>01/17/2025 ,118 ,16 ,128 ,129.8<br><br>**<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on facility census, there were not the required number of Certified Nurse Aides on any day between 1/12/2025 and 1/17/2025.<br><br>To fulfill the staffing requirement for Certified Nurse Aide care per resident per day, a facility with a census of 118 would need to schedule at least 37 staff members with nurse aide certifications for the entire day.<br><br>**<br><br>Date, Facility Census, Scheduled Staff, Actual Scheduled, Required Staffing Hours<br><br>1/12/2025, 118, 14, 112, 289.1<br><br>1/13/2025, 118, 26, 208, 289.1<br><br>1/14/2025, 118, 31, 248, 289.1<br><br>1/15/2025, 118, 30, 240, 289.1<br><br>1/16/2025, 118, 29, 232, 289.1<br><br>1/17/2024, 118, 23, 184, 289.1<br><br>**<br><br>A review of punch cards provided by the facility from 1/12/2024 through 1/17/2025 documented the following:<br><br>To fulfill the staffing requirement for licensed nursing care (Registered Nurses and Licensed Practical Nurses) per resident per day, a facility with a census of 118 would have at least 17 staff members with nursing licenses registered as working the entire day. Per the punched timecards, and based on the facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 1/12/2025 or 1/17/2025.<br><br>**<br><br>Date, Facility Census, Staff Timecard Punches, Actual Scheduled Hours, Required Staffing Hours<br><br>1/12/2025, 118, 12, 96, 129.8<br><br>1/13/2025, 118, 19, 152, 129.8<br><br>1/14/2025, 118, 22, 176, 129.8<br><br>1/15/2025, 118, 25, 200, 129.8<br><br>1/16/2025, 118, 23, 184, 129.8<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 1/17/2025, 118, 14, 112, 129.8<br><br>**<br><br>To fulfill the staffing requirement for Certified Nurse Aide care per resident per day, a facility with a census of 118 would need to schedule at least 37 staff members with nurse aide certifications for the entire day. Per the punched timecards, and based on the facility census, there were not the required number of Certified Nurse Aides on any day between 1/12/2025 and 1/17/2025.<br><br>Date, Facility Census, Staff Timecard Punches, Actual Scheduled Hours, Required Staffing Hours<br><br>1/12/2025, 118, 16, 128, 289.1<br><br>1/13/2025, 118, 23, 184, 289.1<br><br>1/14/2025, 118, 21, 168, 289.1<br><br>1/15/2025, 118, 26, 208, 289.1<br><br>1/16/2025, 118, 19, 152, 289.1<br><br>1/17/2025, 118, 13, 104, 289.1<br><br>During a Resident Council Meeting on 1/14/2025 at 11:07 AM observed by the New York State Department of Health survey team, five out of five residents expressed concerns related to staffing in the building. When asked if they got the help and care they needed without waiting a long time and if staff responded to their call light timely, residents stated they did not, and it could take a good hour for call lights to be answered. The residents noted that it took longer for the call lights to be answered at nighttime. The residents' stated staffing was a disaster on the weekends.<br><br>During an interview on 1/14/2025 at 9:32 AM Family Member #3stated that they had concerns with staffing, particularly on the weekends. The Family Member #3 further stated that they provide personal care and ambulation assistance because staff were not providing the care.<br><br>During an interview on 1/17/2025 at 11:23 AM, Staffing Coordinator #1 stated that they put their schedule in place months in advance and gave it to upper management for review. At the time of the interview, Staffing Coordinator #1 stated they had completed the staffing schedule through May 2025. Every Tuesday and Thursday, upper management and Staffing Coordinator meet to discuss any issues with the schedule as it was written.<br><br>Additionally, the Staffing Coordinator #1 stated that the Director of Nursing should not be in an assignment, but it has happened. It most recently happened over the holidays. Staffing Coordinator #1 stated they used travel nurses or borrow from other corporate facilities. Borrowing from another corporate facility was a last resort.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 1/21/2025 at 2:02 PM Licensed Practical Nurse #1 stated that they worked alone the day before and there was not enough staff at the facility. Licensed Practical Nurse #1 stated that they struggled to complete all their work, but they loved the residents, so they stay even though the work was difficult.<br><br>During an interview on 1/21/2025 at 2:16 PM Registered Nurse #1 stated that there was never enough staff to give everyone the ability to do their job effectively, but they had only been employed at the facility a little over a month and was still learning.<br><br>During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated that they had been the Director of Nursing for 3 months and employed at the facility for 9 months. Director of Nursing #1 stated that it was hard to recruit staff because the pay structure was not good, but the facility was working with the union to increase the amount that can be offered to staff.<br><br>During an interview on 1/23/2025 at 11:03 AM Administrator #1 stated that they used to recruit for the whole building and beginning on 1/06/2025, corporate also started helping with staff recruitment. Administrator #1 stated they spend 2-3 hours a day trying to get staff hired or interviewed.<br><br>10 New York Code Rules and Regulations 415.13(a)(1)(i-iii) |

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|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744<br><br>FACILITY<br><br>Sufficient and Competent Nurse Staffing<br><br>01/13/25 11:37 AM [NAME] O2 cannula not in nose. 2.5L NC on concentrator. Problems at nighttime getting help. + cough. Usually takes 10-15 minutes to get help. Only one person works at night.<br><br>01/17/25 11:23 AM Interview with Deprincess Golden Staffing coordinator<br><br>Given numbers on PBJ that were less than 8h in the building. 7/4 7.5h - looked at punch sheets and stated that the RN was present for 7:05 to 3:04. Asked if took a lunch break would that be a 7.5h day. Couldn't confirm that was the situation for that day.<br><br>7/14 confirmed there was no RN on that day.<br><br>9/20 stated the DON was in the building at the time for full 8h and another RN was here 6.75<br><br>The staff are not allowed to clock in 7 minutes before shift start or 7 minutes before time to leave.<br><br>Puts her schedule in place months in advance and gives it to upper management for review. Right now she has the schedule out to May so that the facility knows well in advance that there aren't 8h scheduled. Every T/Th she meets with the DON and Admin to discuss any staffing issues she has.<br><br>Works with staff to swap hours to try and meet the 8h requirement. For example if a nurse is working a 12h shift 7-7 she will ask them to work 8-8 to meet the requirement.<br><br>The DON shouldn't be in an assignment but it does happen. Recently it happened over the holidays.<br><br>When speaking with Yonni the staffing coordinator will advocate for her staff and stated the admin and DON do listen. They work together to recruit more RNs. Will go to Centers corporate if they need staffing. Deprincess has called Corporate maybe once to advocate for them to send more staff.<br><br>They use Travelers. Some are from local agencies. Some they are from agencies that are outside the state like Louisiana. Have pulled staff from other Centers.<br><br>Stated she recruits staff from people she knows as a health care worker in the past. The staff already in house recruit and send people to her.<br><br>Borrowing from a sister facility is a last resort.<br><br>The LPNs that work w here are really good. There are local RNs that will come in if they need to to do things that LPNs can't do.<br><br>(continued on next page) |

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|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | There is an oncall RN list updated monthly.<br><br>DePrincess does the CNA and LPN orientation. She does not do the RN orientation.<br><br>If the staff are not newly graduate, orientation is usually around 4 days, never shorter. While they are on orientation, they cannot work by themselves. If the staff is a new graduate, the orientation is longer, no less than 6 months but probably about 2 weeks. She does not let anyone loose if the orienting staff state that the new person is ready.<br><br>After the CNA packet is completed in orientation there is a skills assessment test. Licensed person above the new person does a competency test and signs off that the new staff are ready.<br><br>DePrincess does not get involved with performance reviews but does talk to the staff and report upwards if she is hearing that someone isn't ready or isn't a good match for the facility.<br><br>Stated home grown staff and contractors want to be here and ask to come back.<br><br>01/23/25 11:03 AM Yonni interview. Until 1/6 he was doing recruiting for the whole bldg. Constantly reaching out to corporate and uses PLOY which is a website that funnels online resumes and applications. Corporate took it over on 1/6 and now he spends 2-3 hours a day trying to get staff hired or interviewed.<br><br>There is a sign on and referral bonus. They go to job fairs to try and recruit nursing students. Tries to set up clinical rotations to come to the bldg. Is talking to CDTA to get them to put a bus stop in front of the bldg to make the building more accessible. |

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|---|---|
| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744<br><br>Based on interview and record review conducted during the recertification survey, the facility did not use the services of a Registered Nurse for at least eight consecutive hours a day, seven days a week. Specifically, a review of staffing revealed a Registered Nurse was not scheduled for eight consecutive hours per day on multiple dates from July 4, 2024, to September 28, 2024.<br><br>This is evidenced by:<br><br>The facility assessment dated ,d+[DATE] documented that the staffing plan was based on the resident population and their needs for care and support. The staffing plan documented the following daily staffing needs:<br><br>Shift Category of Staff Number of Staff Total Hours Worked<br><br>Days Registered Nurse 1-4 7.5-30<br><br>Evenings Registered Nurse 0-1 0-7.5<br><br>Nights Registered Nurse 0-1 0-7.5<br><br>The facility Job Title Report dated 7/1/2024 to 9/30/2024 documented that the facility did not have a registered nurse for 8 consecutive hours in the facility on the following dates: 7/04/2024, 7/14/2024, and 9/20/2024.<br><br>There were no staffing waivers in place for the facility both before the recertification survey or during the recertification survey.<br><br>During an interview on 1/17/2025 at 11:23 AM, Staffing Coordinator #1 stated that there was a Registered Nurse in the building on 7/04/2024 for 7.5 hours. When asked why the registered nurse was scheduled for 7. 5 hours, not 8, Staffing Coordinator #1 stated they could not confirm what the situation was for that day. Additionally, Staffing Coordinator #1 confirmed there was no Registered Nurse scheduled for 8 hours on 7/14/2024 but was unable to speak as to why. Staffing Coordinator #1 stated that on 9/20/2024 there was a Registered Nurse in the facility for 6.75 hours, however the Director of Nursing was also here that day and they were scheduled for 8 hours. Staffing Coordinator #1 stated that they put their schedule in place months in advance and gave it to upper management for review so that the facility knew well in advance if there were not 8 hours of Registered Nurse coverage scheduled. Staffing Coordinator #1 stated that every Tuesday and Thursday, Staffing Coordinator #1 met with the Director of Nursing and the Administrator to discuss any staffing issues that had been identified. Staffing Coordinator #1 stated that they worked with staff to swap hours to try and meet the 8-hour requirement. For example, if a nurse was working a 12-hour shift 7 AM to 7 PM, Staffing Coordinator #1 stated they would ask them to work 8 AM to 8 PM to meet the requirement. Staffing Coordinator #1 stated that the Director of Nursing should not be in an assignment, but it has happened. Recently it happened over the holidays.<br><br>(continued on next page) |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/23/2025 at 8:44 AM, Director of Nursing #1 stated there were no Registered Nurses working in the facility that had been employed with the facility for more than a year. Director of Nursing #1 stated that they were not the Director of Nursing in July or September and was therefore unable to speak to the lack of 8 hours of Registered Nurse coverage. Director of Nursing #1 stated that they try to work on staffing issues as far in advance as they were able to.<br><br>During an interview on 1/23/2025 at 11:03 AM, Administrator #1 stated that staffing was a struggle. They had spent a lot of time working on recruiting staff until 1/06/2025. Administrator #1 was unable to speak to what happened on the three dates without 8 consecutive hours of Registered Nurse coverage in the facility.<br><br>10 New York Code Rules and Regulations 415.13(b)(1) |

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| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>51317<br><br>Based on observations, record reviews, and interviews during recertification survey, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs, which was any drug used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences which indicated the dose should be reduced or discontinued for 1 (Resident #27) of 5 residents reviewed for unnecessary medications. Specifically, Resident #27's physician order for Estrace (a vaginal cream) did not include an indication for use in accordance with professional standards.<br><br>This is evidenced by:<br><br>Resident #27 was admitted to the facility with diagnoses of urinary tract infection, unspecified dementia, and major depressive disorder The Minimum Data Set (an assessment tool) dated 11/18/2024 documented the resident had severe cognitive impairment, could be understood and understand others.<br><br>Policy titled Medication Regimen Reviews created 05/2019 last revised 11/2021 documented the consultant pharmacist reviews the medication regimen of each resident at least monthly. The medication regimen review involved a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors and other irregularities for example: medications ordered in excessive doses or without clinical indication.<br><br>Resident #27's physician order dated 08/16/2024 documented Estrace Vaginal Cream 0.1 MG/GM (Estradiol Vaginal). Insert 1 application vaginally one time a day every Tue, Fri for apply a small pea size amount to external vaginal opening. There was no documented evidence indication for the use of Estrace Vaginal Cream.<br><br>Consultant Pharmacist's Medication Regimen Review for recommendations created between 12/01/2024 and 12/30/2024 documented a medication regimen review occurred for Resident #27 on 12/11/2024. It documented resident's medication regimen had been reviewed and there were no irregularities noted at this time.<br><br>Review of Resident #27's care plan did not document the use of Estrace Vaginal Cream , and it did not document the indication for this medication.<br><br>During an interview on 01/16/2025 at 11:00 AM, Licensed Practical Nurse #1 stated medication orders were supposed to have a reason why the medication was given. If there was no reason indicated, one should call the doctor and ask them to put it in. Licensed Practical Nurse #1 was shown Resident #27's order for Estrace Vaginal Cream. Licensed Practical Nurse #1 stated the order did not show a reason why this medication was given, and they would ask the Physician Assistant to include an indication for use of this medication on the order.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/16/2025 at 11:08 AM, Registered Nurse #1 was shown Resident #27's order for Estrace Vaginal Cream. They acknowledged an indication for use of this medication was missing. Registered Nurse #1 stated they would reach out to the provider if there was no indication for use, and they would not use the medication again until the indication was there. They stated sometimes the provider did not include an indication for use and they would call the provider if the indication was not there.<br><br>During an interview on 1/21/2025 and 10:12 AM, Director of Nursing #1 stated that orders should include the reason for use. The admission nurse or unit manager enters the information for the orders, and the physician should indicate why the resident received the medication. They stated when nurses enter the orders for a medication, it should include an indication for use.<br><br>During an interview on 01/21/2025 at 8:57 AM, Provider #1 stated they did not put anything down for indication for a medication on the order. The nurses entered the indication on the order sheet. When asked what they would do if there was no indication for a medication's use, Provider #1 stated they knew what the indication for use was. If a nurse were to ask them what the indication for use was, they would tell the nurse.<br><br>During an interview on 01/23/2025 at 11:55 AM, Medical Director #1 stated the nurses entered the orders for the residents. When asked if the physician provided the indication for use of the medication on the order, they stated as far as they were concerned the indication for use of medications was in their clinical notes. The reason for indication for use of a medication was documented by the provider under progress notes. They stated nurses should give the medication based on the order that was coming from the provider who is competent to give that order.<br><br>10 New York Code of Rules and Regulations 415.12(l)(1) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>48615<br><br>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 5% for 1 (Resident #5) of 7 residents observed during a medication pass for a total of 27 observations. This resulted in a medication error rate of 22.22%.<br><br>This is evidenced by:<br><br>The facility's Policy and Procedure titled, Medication Administration revised 12/2019, documented medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label three (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>Resident #5 was admitted to the facility with a diagnoses of muscle weakness, depression and dementia unspecified (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set (an assessment tool) dated 11/2024, documented resident was severely cognitively impaired, could be understood, and understand others.<br><br>The Medication Administration Record dated 1/01/2025 for Resident #5, documented orders as follows: Give Eliquis 2.5 milligram tablet daily; Metoprolol Tartrate 50 milligram tablet daily; Lotrel 10-20 milligram capsule daily; Calcium Vitamin D3 500-10 tablet daily; Omeprazole 40 milligram delayed release daily; Tradjenta 50 grams tablet daily.<br><br>The following were manufacturer recommendations: Calcium Vitamin D3 500-10: Do not crush, chew, or break an extended-release tablet. Omeprazole 40 milligrams delayed release: Do not chew or crush omeprazole delayed-release capsules. Tradjenta 50-gram tablet: The tablets must not be split, crushed, dissolved, or chewed before swallowing.<br><br>The Medication Administration Record dated January 2025, for Resident #5, did not include a crush medication order.<br><br>During an observation on 01/16/2025 at 9:06 AM, Registered Nurse #3 poured, crushed and administered the following medications to Resident #5: Eliquis 2.5 milligram tablet; Metoprolol Tartrate 50 milligram tablet; Lotrel 10-20 milligram capsule; Calcium Vitamin D3 500-10 tablet; Omeprazole 40 milligram delayed release tablet; and Tradjenta 50 grams tablet.<br><br>During an interview on 01/16/2025 at 9:15 AM, Registered Nurse #3 stated they discussed medication administration route with Registered Nurse #1 (unit manager), and was advised to crush the above medications in separate cups then administer to Resident #5.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 01/16/2025 at 9:33 AM, Registered Nurse #1 stated they advised Registered Nurse #3 NOT to crush Vitamin D3 Omeprazole and Tradjenta . Instead, they should put Vitamin D3 Omeprazole and Tradjenta in a separate cup and give whole with yogurt. Registered Nurse #1 stated residents who received crushed medications have orders in the Medication Administration Record. When reviewing Resident #5's Medication Administration Record, Registered Nurse #1 was unable to locate orders to crush medications. Registered Nurse #1 stated they would obtain orders and update.<br><br>During an interview on 01/16/2025 at 10:45 AM, Director of Nursing #1 stated nursing staff received new hire orientation including medication administration. Nurses were assigned a preceptor who completed the orientation checklist of skills. A medication pass was demonstrated with competency prior to signing off checklist. There was no post-test. The 5 rights of medication administration per policy were to be followed. Director of Nursing #1 stated there should be a physician order for crushing medication in the Medication Administration Record, also noted in special comments. They also stated if a resident required medications to be crushed, a medication that could not be crushed would not be prescribed. The physician would have to write an alternate order. They stated they would address medication error after survey.<br><br>10 New York Codes, Rules, and Regulations 415.12 (m)(1)] |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>51131<br><br>Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents were free of any significant medication errors for 1 (Resident #s 62) of 40 residents reviewed. Specifically, Resident #62 was not given Alprazolam (used to treat anxiety) at the prescribed therapeutic times. Additionally, there was no documented evidence that physician was notified, and that Resident #62 was monitored for side effects.<br><br>This is evidenced by:<br><br>Resident # 62 was admitted to the facility with diagnoses of pubic ramus fracture (a fracture of the pubic bone), primary osteoarthritis (arthritis of the bones and joints), left shoulder, and muscle weakness. The Minimum Data Set (an assessment) dated 12/24/2024 documented the resident had intact cognition, could be understood, and understand others.<br><br>The facility's Policy and Procedure titled Medication Administration revised 12/2019, documented medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must check the label three (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication.<br><br>During an interview on 01/14/2025 at 11:40 AM, Resident #62 stated the night nurse came in a week ago and gave Tylenol and Alprazolam (Xanax) at 5:30 PM. They came in again at 7:30 PM to give their night pills including another Xanax. When Resident #62 refused, Nurse left the pills on the table and told resident take them or not, I don't care.<br><br>The Medication Administration Record dated 12/17/2024 through 1/15/2025 documented give Alprazolam 0. 5 milligrams at 09:00, 16:00, and 21:00.<br><br>The Physician's order dated 12/18/2024 documented give Alprazolam 0.5 milligram 1 tablet by mouth three times a day for anxiety.<br><br>The Physician's order dated 12/18/2024 documented give Alprazolam 0.5 milligram 1 tablet by mouth every eight hours as needed for anxiety for 14 days. Order was discontinued on 1/1/2025. Resident received one as needed dose on 12/18/2024 at 11:02 AM.<br><br>On 12/18/2024:<br><br>09:00 dose was not administered.<br><br>11:02 AM Resident received as needed dose.<br><br>16:00 dose administered at 18:33 - given 2 1/2 hours late<br><br>21:00 dose administered at 20:08 - given 1 hour early, and 2 hours after previous dose.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/24/2024:<br><br>Alprazolam 0.5 milligram ordered at 16:00 and 21:00 were administered at 17:23 and 20:30 respectively. Medication given three hours apart.<br><br>On 12/26/2024:<br><br>Alprazolam 0.5 milligram ordered at 16:00 and 21:00 were administered at 17:52 and 20:37 respectively. Medication given 2 hours and 15 minutes apart<br><br>On 12/28/2024:<br><br>Alprazolam 0.5 milligram ordered at 09:00 AM. Administered at 12:00 PM. Given 3 hours late.<br><br>On 1/02/2025:<br><br>Alprazolam 0. 5 milligram ordered at 16:00 and 21:00 were administered at 16:57 and 20:03 respectively, 3 hours and 6 minutes apart.<br><br>On 1/04/2025:<br><br>Alprazolam 0.5 milligram ordered for 16:00 and 21:00 were administered at 17:24 and 20:34 respectively, 3 hours and 10 minutes apart.<br><br>On 1/06/2025:<br><br>Alprazolam 0.5 milligram ordered for 16:00 and 21:00 were administered at 17:20 and 20:20 respectively, 3 hours apart.<br><br>During an interview on 01/16/2025 at 10:45 AM, Director of Nursing #1 stated nursing staff received new hire orientation including medication administration. They stated Nurses were assigned a preceptor who completed the orientation checklist of skills. A medication pass was demonstrated with competency prior to signing off checklist. The 5 rights of medication administration per policy were to be followed including right time that medication was administered. They stated if a medication was given late the physician should be notified.<br><br>During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse # 3 stated all medications should be given as ordered by the physician and written in the Medication Administration Record. They stated the Unit Manager checked the dashboard to determine whether the medications were given, and at the end of the month the unit manager checked that all medications were signed for on the Medication Administration Record.<br><br>During an interview on 1/21/2025 at 1:17 PM, Licensed Practical Nurse #4, (Unit Manager) and Licenses Practical Nurse #3 stated they agree that administering Xanax at 18:33 and then again at 20:08 was a medication error. Both stated they were unaware of the Xanax medication errors.<br><br>10 New York Codes, Rules, and Regulations 415.12(m)(2) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615<br><br>Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for 3 of 3 medication carts (Unit G, Cart 2; Unit C, Cart 2; Unit D, Cart 1) and 2 of 2 medication rooms (Unit G and Unit B units) reviewed. Specifically, (a.) opened medications had no open and or expiration dates (b.) 1 open vial of insulin had an expired date: (c.) discontinued medications were stored in medication carts and refrigerator; (d.) 2 narcotic boxes were not double locked; (e.) and personal items were stored in medication carts and medication room.<br><br>This is evidenced by:<br><br>The facility's Policy and Procedure titled Medication Storage, revised ,d+[DATE], documented this center would have Medications stored in a manner that maintained the integrity of the product, ensures the safety of the residents, and in accordance with Department of health guidelines. Medications would be stored in an orderly, organized manner in a clean area. Expired, discontinued and/or contaminated medications would be removed from the medication storage areas and disposed of in accordance with facility policy.<br><br>The facility's Policy and Procedure titled Medication Administration, revised ,d+[DATE], documented the expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date should be recorded on the container. Refer to Pharmacy guidance for expiration of opened medications.<br><br>PART 80. RULES AND REGULATIONS ON CONTROLLED SUBSTANCES NEW [NAME] STATE, (1) Schedule I, II, III and IV controlled substances shall be kept in stationary, locked double cabinets. Both cabinets, inner and outer, shall have key-locked doors with separate keys; spring locks or combination dial locks are not acceptable.<br><br>During an observation on [DATE] at 10:04 AM, Unit G cart 2 contained the following medications with no open and or expiration dates: 2 albuterol inhalers; 1 DuoNeb liquid vial; 1 bottle of Prednisone eye drops, 1 bottle Brimonidine eye drops, 1 bottle of lispro insulin, 1 Novolog insulin pen, 2 Fluticasone nasal sprays, 1 bottle of Miralax powder, and 1 bottle of Lactulose liquid. 1 can of ginger-ale, 1 telephone charger, a note pad with a list of employee telephone numbers were also noted in medication cart #2.<br><br>During an observation on [DATE] at 10:30 AM, the Unit G unit medication room Narcotic Box 2 west, the inside lock was found open. The mediation room refrigerator contained 1 unopened bottle of Purified Protein Derivative, was inside of a box labeled opened on [DATE]. The medication room refrigerator had no lock. Inside the refrigerator had 1 lockbox containing 1 vial of lorazepam injectable. There were 2 coats, and 2 sweaters belonging to staff noted in the medication room.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on [DATE] at 10:46 AM, the Unit C Medication Cart 2 contained glucose tablets with no resident name. Licensed Practical Nurse # 5 stated this was not a stock item. The sharps container on side of medication cart was full and unanchored. 1 tube of Diflucan gel with an expiration date of [DATE] belonging to a discharged resident was noted on cart. 1 box of TUCKS hemorrhoid pads that had been discontinued on [DATE] was found on cart. The medication room refrigerator for Unit B and Unit C contained 1 unopened box of Ozempic, filled on [DATE], belonging to a discharged resident was noted.<br><br>During an observation on [DATE] at 11:35 AM, The Unit D, Medication Cart D contained 1 bottle of Fluticasone nasal spray; 1 bottle of Systane eye drops both with no open and or expiration dates. The following stock medications had no open dates: 1 bottle of Mucus ER, Melatonin, Omeprazole, Gas Ban, All-Day Allergy Relief, Vitamin B12, Vitamin D3, Sodium Chloride Tablets, Multivitamin tablets and Acidophilus probiotics. 1 Novolog insulin pen and 1 Admelog Solostar insulin pen both had illegible expiration dates. 1 bottle of Geri [NAME] had two conflicting dates of [DATE] and ,d+[DATE]. 1 bottle of Geri Tussin was soiled with dirt and syrup. The medication cart narcotic box was found unlocked.<br><br>During an interview on [DATE] at 11: 40 AM, Registered Nurse #3 stated they were unaware of medications that have a shortened expiration date after opening.<br><br>During an interview on [DATE] at 11:50 AM, Licensed Practical Nurse #6 stated they are a float nurse and not familiar with the floor or cart. They were unaware of medications that have a shortened expiration date after opening.<br><br>During an interview on [DATE] at 1:13 PM, Director of Nursing #1 stated it was the responsibility of the medication nurse to ensure the medication cart was clean and orderly. All nurses received medication training and were observed for medication pass competency prior to passing medication independently. The medication nurse checked expiration dates prior to giving medications. Multi-vial medications and medications with shortened expiration dates should be labeled by the medication nurse upon opening.<br><br>10 New York Codes, Rules, and Regulations 415.18(d) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34630<br><br>Based on observation and interviews during the recertification survey, the facility did not ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in 3 (A/D, B/C, and G units) of 3 resident unit nutrition rooms and the main kitchen. Specifically, the area of the main kitchen and resident kitchenettes were not clean.<br><br>This is evidenced by:<br><br>During the initial inspection in the main kitchen on 1/13/2025 at 11:20 AM, the following observations were made:<br><br>The rolling toaster appliance had a large amount of buildup and debris on the device.<br><br>The meat slicer had dirt and debris on and under the device.<br><br>Cooler #1 had a broken seal with dirt and debris in the seal.<br><br>Cooler #3 had a broken seal around the lid not allowing proper sealing.<br><br>The top of the Accutemp steamer had dirt and debris on the equipment.<br><br>Areas of the kitchen floor were dirty and needed cleaning.<br><br>The walk-in freezer doorway had significant ice build-up around the doorway and would not allow the door to fully close.<br><br>During the follow-up inspection in the main kitchen on 1/15/2025 at 11:00 AM, the following observations were made:<br><br>The walk-in freezer door was not closed with ice build-up around the doorway and on the condenser in the freezer.<br><br>The storage area for clean pots, pans, and food containers had multiple containers stacked together that were not fully dried. Containers, pots, and trays were put away wet and contained moisture.<br><br>The rolling toaster contained a large amount of debris on buttons and rolling apparatus.<br><br>The meat slicer had debris under and around the slicer.<br><br>Chemical sanitizer in three sink systems when tested with Hydrion test strip read closer to 500 parts per million on the test strip.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 1/15/2025 at 12:15 PM, the G unit nutrition room had an out-of-service ice machine that was rusted and had open areas. The cabinet doors and handles were broken, and the counters were covered with dirt and debris.<br><br>During an observation on 1/15/2025 at 12:22 PM, the B/C unit's nutrition room had broken cabinet doors with broken handles, and the counters had dirt and debris on them.<br><br>During an observation on 1/15/2025 at 12:30 PM, the A/D unit's nutrition room counters had dirt and debris on them, and the door seals for the refrigerator and freezer had dirt and debris on them.<br><br>During a follow-up observation of the main kitchen on 1/22/2025 at 11:35 AM, the rolling toaster was not cleaned and still had a large amount of debris on the device.<br><br>During an interview on 1/22/2025 at 11:45 AM, Director of Food Services #1 stated their staff was responsible for the cleaning of the refrigerators in the nutrition rooms and that housekeeping was responsible for the rooms themselves. They stated they wanted to dispose of the ice machine in that room as it was a hazard and could have mold. They stated that all the other ice machines in the other units were removed. Food Service Director #1 stated they had been at the facility for the last 6 months and had been making progress in tightening up some things in the interim. They stated that they had plans for the nutrition rooms and some of the equipment in the kitchen. They stated they would need to be more diligent in the cleaning of the equipment and areas within the kitchen. They stated they may need to get a new toaster if they were unable to fully clean it. They stated that the staff member who washed the pots, pans, and containers did not let them dry fully and put them away too soon as it took several hours to fully dry. Director of Food Service #1 stated that the chemical sanitizer in the three-sink system should read anywhere from 300 - 400 parts per million range. In showing them the test strip reading closer to the 500 parts per million reading they stated they would need to get the service company in to adjust the concentration.<br><br>48413<br><br>During an interview on 1/25/2024 at 11:45 AM, Director of Housekeeping #1 stated their staff was responsible for the overall cleaning in the nutrition rooms but not the refrigerators. They stated that they had not received any complaints about the cleanliness of the rooms and staff were expected to clean the areas within the rooms.<br><br>10 New York Codes, Rules, and Regulations 415.14(h) |

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| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>48744<br><br>Based on observation, record review, and staff interviews during the recertification survey, the facility did not ensure safe and sanitary storage of foods brought to residents by families and other visitors to prevent food-borne illness for 1 (Resident #52) of 1 resident reviewed for outside food. Specifically, Resident #52's food brought from outside was not labeled and discarded per the facility policy.<br><br>This is evidenced by:<br><br>Resident #52 was admitted to the facility with the diagnoses of unilateral inguinal hernia with obstruction (when tissue, such as part of the intestine, protrudes through a weak spot in the abdominal muscles causing pain and obstruction to the intestine), hepatomegaly (a condition where the liver is larger than normal), and type 2 diabetes mellitus (a chronic disease that occurs when the body can't use insulin properly, resulting in high blood sugar levels). The Minimum Data Set (an assessment tool) dated 12/25/2024 documented the resident was cognitively intact, could be understood, and understand others.<br><br>The document titled, Food Brought in from Outside Facility, revised on 3/25/2022, documented that families or visitors would be educated on safe food handling practices for food brought in from outside the facility. Food or beverages brought in from the outside would be monitored by nursing staff for spoilage, contamination, and safety. The policy further documented that a refrigerator and microwave were available to residents and families to ensure that foods were stored and served at a safe temperature. Nursing staff would monitor resident's rooms for food and beverage disposal.<br><br>During an observation on 01/13/2025 at 1:55 PM, Resident #52 had 3 raw hotdogs in their room, in their dresser, and had a Tupperware container at their bedside with rice in it. Resident #52 stated that their family member brought them food in the morning.<br><br>During an interview on 01/14/2025 at 7:45 AM, Family Member #1 stated that when Resident #52 was on the D unit, the staff would take the food from them and put it in the refrigerator for the resident. They stated that since the resident was moved to the G unit, the staff had not been asking to place the food in the refrigerator and had let the resident keep the food in the room unmonitored. When Family Member #1 was asked if the staff ever discussed with them the food from outside policy regarding safe storage of food brought in to the resident, they stated that they had not received any education regarding the policy.<br><br>During an interview on 01/21/2025 at 2:02 PM, Licensed Practical Nurse #1 stated that the family was aware if they were to bring outside food to the resident, they were to give it to the staff, so that it could be placed in the unit refrigerator. When Licensed Practical Nurse #1 was asked about the food that was observed in the resident's room, they stated they did not have any knowledge that it was there.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 01/21/2025 at 2:16 PM, Registered Nurse #1 stated that they expected staff to take the food from the family and inspect it for multiple issues. They expected staff to look at the food for consistency, diet compliance, safeness to eat, and/or temperature. They stated that if they identified any significant issues, they would reach out to the Speech-Language Pathologist or Dietician for guidance. Registered Nurse #1 stated that overall, they would take the food to examine it and store it properly.<br><br>During an interview on 01/23/2025 at 8:44 AM, Director of Nursing #1stated they did not know the specifics of the Food from Outside Facility policy and had to read certain areas of the policy. They stated that they would expect Certified Nurse Aides to ask about the food, if residents had any food items in their room. They stated that they would expect that if there were any problems with food in the resident's room, the staff would notify the proper supervision.<br><br>10 New York Code of Rules and Regulations 483.60(i)(3) |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>48413<br><br>Based on observation during the recertification survey, the facility did not dispose of garbage and refuse properly for 2 of 3 trash bins. Specifically, 2 trash bins were not pest and rodent-proof with trash bin doors not fully closed, and the drain plug was not secured.<br><br>This is evidenced as follows:<br><br>During an inspection on 1/15/2025 at 12:48 PM, garbage waste was found around the dumpsters. the right dumpster did not have a drain plug, and the left dumpster side door was open.<br><br>During an interview on 1/23/2025 at 10:35 AM, Director of Maintenance #1 stated they were responsible for the dumpsters and the area. They stated the left dumpster was for the adult apartment facility, but it was still their responsibility. They stated that they would clean up the area daily but refuse still litters the ground around the dumpsters throughout the day. They stated that they noticed that the right dumpster did not have a drain plug cover and contacted the dumpster vendors to have one placed.<br><br>In a follow-up observation of the dumpster area on 1/23/2025 at 10:40 AM, During the follow-up observation, the Director of Maintenance #1 observed that the side door was open on the dumpster and had to close it themselves. They stated that they needed to make sure everyone was aware to close the dumpster doors after disposing of garbage.<br><br>10 New York Code of Rules and Regulations 415.14(h) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>48413<br><br>Based on observation, resident and staff interviews, review of facility policies and procedures, staffing records, resident records, accident and incident reports, and the facility's maintenance records, during the recertification survey, it was determined the facility was not administered in a manner to effectively use its resources to attain or maintain the highest practicable well-being of each resident. The administration failed to ensure the facility was in compliance with the following regulatory requirements, which affected or potentially affected all residents in the facility. These failed practices directly impacted 39 of 39 residents sampled (Resident #s 3, 6,13, 14, 17, 22, 24, 27, 34, 38, 39, 40, 42, 46, 51, 52, 56, 58, 60, 62, 68, 75, 92, 97, 102, 103, 107, 108, 109, 160, 210, 211, 212, 213, 218, 260, 261, 362, 364). Specifically, the lack of effective oversight and planning on the part of facility administration had the potential to adversely affect the health and safety of all residents residing in the facility.<br><br>This is evidenced by:<br><br>1) Deficiencies related to ineffective administration:<br><br>Please refer to F550 as it pertains to the facility's failure to resident dignity.<br><br>Please refer to F554 as it pertains to the facility's failure to assess the resident's ability to self-administer medications.<br><br>Please refer to F577 as it pertains to the facility's lack of accessibility of the survey results in the facility.<br><br>Please refer to F584 as it pertains to the facility's failure to provide a a safe, clean, comfortable and homelike environment.<br><br>Please refer to F585 as it pertains to the facility's failure to provide availability for residents to file a grievance or complaint.<br><br>Please refer to F600 as it pertains to the facility's failure to ensure residents were free from abuse and neglect.<br><br>Please refer to F609 as it pertains to the facility's failure to ensure injuries from unknown sources were reported to the State Survey Agency.<br><br>Please refer to F622 as it pertains to the facility's failure to provide residents with a safe and appropriate discharge.<br><br>Please refer to F623 as it pertains to the facility's failure to notify the Office of the State Long-Term Care ombudsman office on discharges.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Please refer to F625 as it pertains to the facility's failure to provide a notice of discharge or bed hold policy when discharged to the hospital.<br><br>Please refer to F645 as it pertains to the facility's failure to assess residents with mental or intellectual disabilities received preadmission screening.<br><br>Please refer to F656 as it pertains to the facility's failure to develop and implement a comprehensive person-centered care plan for each resident.<br><br>Please refer to F657 as it pertains to the facility's failure to review and revise a comprehensive person-centered care plan for each resident.<br><br>Please refer to F679 as it pertains to the facility's failure to provide activities based on comprehensive assessment, care plan, and preferences of each resident.<br><br>Please refer to F684 as it pertains to the facility's failure to ensure services provided met professional standards.<br><br>Please refer to F689 as it pertains to the facility's failure to ensure residents were free of accidents and hazards.<br><br>Please refer to F692 as it pertains to the facility's failure to ensure acceptable parameters of nutritional status and sufficient fluid intake to maintain proper hydration .<br><br>Please refer to F695 as it pertains to the facility's failure to ensure respiratory care services provided met professional standards.<br><br>Please refer to F725 as it pertains to the facility's failure to ensure sufficient staffing services provided met professional standards.<br><br>Please refer to F726 as it pertains to the facility's failure to ensure competent nursing services provided met professional standards.<br><br>Please refer to F727 as it pertains to the facility's failure to provide Registered Nursing staff for a minimum of 8 consecutive hours 7 days per week.<br><br>Please refer to F757 as it pertains to the facility's failure to ensure each resident's drug regimen was free from unnecessary medications without adequate indications.<br><br>Please refer to F759 as it pertains to the facility's failure to endure medication error rates were less than 5%.<br><br>Please refer to F760 as it pertains to the facility's failure to ensure residents were free of any significant medication errors.<br><br>Please refer to F761 as it pertains to the facility's failure to ensure the storage of drugs and biologicals met professional standards.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Please refer to F812 as it pertains to the facility's failure to store, prepare, distribute, and serve food met professional food service safety standards.<br><br>Please refer to F813 as it pertains to the facility's failure to ensure the use and storage of foods, brought to residents by family and other visitors met professional food service safety standards.<br><br>Please refer to F814 as it pertains to the facility's failure to ensure garbage and refuse were disposed of properly.<br><br>Please refer to F842 as it pertains to the facility's failure to ensure medical records for residents were complete and accurate.<br><br>Please refer to F868 as it pertains to the facility's failure to maintain a quality assurance program.<br><br>Please refer to F880 as it pertains to the facility's failure to ensure infection control practices met professional standards.<br><br>Please refer to F882 as it pertains to the facility's failure to have an Infection Preventionist provide a distinct role.<br><br>During an interview on 1/23/2025 at 4:05 PM Administrator #1 stated that they held Quality Assurance meetings every month and it was the responsibility of the staff to sign in for the meetings. Administrator #1 stated that they along with the nursing staff, and heads of all the departments attend the meetings. The Quality Assurance meetings focus on making sure that the facility is in 100% compliance and to discuss problems or concerns that they find. Administrator #1 stated that they identify and recognize items to address and attend to correcting the problem. They stated that they have identified some system failures and were trying to correct them as best as possible.<br><br>10 New York Code of Rules and Regulations 483.70(i) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>34630<br><br>Based on record review and interview during the recertification survey, the facility did not ensure in accordance with accepted professional standards and practices, it maintained medical records on each resident that were complete, accurately documented, readily accessible, and systematically organized for 1 (Resident #34) of 40 residents reviewed. Specifically, Resident 34's Treatment Administration Record was not accurately documented on 1/12/2025.<br><br>This is evidenced by:<br><br>Cross-referenced to: F684: Quality of Care<br><br>Resident #34 was admitted to the facility with diagnoses of disruption or dehiscence (splitting open) of internal surgical wound of abdominal wall muscle, surgical aftercare following surgery on the digestive system, and personal history of malignant neoplasm (cancer) of the large intestine. The Minimum Data Set (an assessment tool) dated 1/2/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>During an observation on 1/13/2025 at 1:53 PM, Resident #34's abdominal dressing was noted with dry, brown-colored drainage and was dated 1/11/2025. Resident #34 stated they had abdominal surgery and had stitches. They stated that when they were in the previous rehabilitation facility, the wound opened, and they had to close it. They stated they did not feel facility nursing staff was monitoring their incision and abdomen the way they should be.<br><br>The Order Recap Report dated 12/1/2024 to 1/31/2025, documented an order dated 12/23/2024 to cleanse abdominal wound with normal saline wet; pat dry with clean gauze; apply saline wet-to-moist gauze to wound bed; cover with abdominal pad; secure with dressing retention tape; every evening shift for wound care.<br><br>Review of the Treatment Administration Record dated January 2025, documented the resident's abdominal wound treatment was administered by Licensed Practical Nurse #8 on 1/12/2025.<br><br>During an interview on 1/23/2025 at 8:53 AM, Registered Nurse #2 stated they were not aware that Licensed Practical Nurse #8 had signed the Treatment Administration Record on 1/12/2025, but did not do the treatment. They stated they were not aware Resident #34 had a concern about their dressing changes not being done. Registered Nurse #2 stated the only time they knew the dressing was changed for certain was on Monday 1/20/2025, during wound rounds.<br><br>During an interview on 1/23/2025 at 9:39 AM, Director of Nursing #1 stated that the minute they found out the dressing was not changed on 1/12/2025, Licensed Practical Nurse #8 was written up and received a final warning. They stated Licensed Practical Nurse #8 documented the treatment was done on 1/12/2025, but did not change the dressing.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/23/2025 at 10:57 AM, Licensed Practical Nurse #8 stated that on 1/12/2025, there was a patient that needed to be sent to the hospital, and they were called off the unit. They stated they did click it as being done before it was done, and their intention was to go back in the room and change the dressing.<br><br>10 New York Code of Rules and Regulations 415.22(a)(1-4) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>48413<br><br>Based on interviews, record reviews, and review of facility policy, the facility failed to maintain a quality assurance committee that met with the participation of all required members, including the director of nursing, Medical Director or designee, Administrator, and Infection Preventionist. The failure to meet to coordinate and evaluate the need for performance improvement projects had the potential to affect all residents of the facility.<br><br>This is evidenced by:<br><br>A review of the facility's undated Quality Assurance and Performance Improvement Plan, revealed that the Quality Assurance and Performance Improvement Plan provides leadership through its committee. The Quality Assurance and Performance Improvement committee shall be comprised of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Facility Educator, Unit Managers, Wound Nurse, nursing and ancillary staff, and all department heads. The Administrator is the chairperson of the Quality Assurance and Performance Improvement committee and is responsible for ensuring that Quality Assurance and Performance Improvement are implemented throughout the facility. The Quality Assurance and Performance Improvement Committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments, services, or committees. The overall responsibility of the steering committee is to develop and modify the Quality Assurance and Performance Improvement, identify teams who will problem solve as well as set priorities for the Performance Improvement Projects.<br><br>A Review of Policy and Procedure titled Infection Prevention and Control created 10/2015 and revised 5/30/2024 documents under Policy Implementation: Through oversight of the Quality Assessment and Assurance Committee, the Infection Prevention and Control Committee, shall oversee the implementation of infection control policies and practices, and help department heads and managers implement infection prevention and control measures within their departments: and, inquiries concerning infection control policies, procedures, and facility practices should be referred to the Infection Preventionist or Director of Nursing Services.<br><br>A review of the last six months of Quality Assurance meeting attendance records revealed that meetings were held from July 2024 through December 2024. A review of the sign-in sheets for these meetings revealed no evidence that the Medical Director or designee attended the 2024 meeting or Infection Preventionist attended any of these meetings.<br><br>During an interview conducted on 01/17/2025 at 12:05 PM, Director of Nursing #1 stated they were the current Infection Preventionist as well as the Nurse Educator. They stated there had not been anyone available to complete the role of Infection Preventionist up to the current time. They stated they had been trying to promote a nurse to the Assistant Director of Nursing role and stated they thought the nurse already had their Infection Preventionist certification. They stated the nurse would be offered training if they did not.<br><br>(continued on next page) |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 1/23/2025 at 4:05 PM, Administrator #1 stated that they held meetings every month and it was the responsibility of the staff to sign in for the meetings. They stated that the Medical Director was at the December 2024 meeting but must have failed to sign in. They stated that they were unaware that the Infection Control Preventionist was their own role and could not be a dual role with the Director of Nursing.<br><br>10 New York Code of Rules and Regulations 415.27(b)(3) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630<br><br>Based on observation, record review, and interviews during the recertification survey the facility did not provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections; and maintain an infection prevention and control practices designed to help prevent the development and transmission of communicable diseases and infection for all resident's and staff on 4 of 4 units. Specifically, (a.) during general observations staff were observed not putting on and taking off Personal Protective Equipment or practicing hand hygiene while entering and exiting residents' rooms with Transmission and Enhanced Barrier Precautions; (b.) for Resident #218, oxygen tubing was observed lying on the floor; (c.) Resident #17 was observed with urinary catheter bag lying on the floor; and (d.) catheter care for Resident #364 was not maintained as ordered to prevent urinary tract infection and urinary catheter bag was observed lying on the floor.<br><br>48413<br><br>This was evidenced by:<br><br>Cross referenced to F882<br><br>Policy and Procedure titled, C-IC-1 Infection Prevention and Control, created 10/2015 and revised 5/30/2024 documented: Policies, procedures, and practices of Infection Prevention and Control in the facility were designed to: Prevent, identify, report, investigate, and control infections and communicable diseases in the facility through a system of surveillance; Identify and determine, when possible, incidents of communicable disease or infections should be stated; Maintain a safe, sanitary, and comfortable environment for residents, healthcare personnel, visitors, and others who may visit the facility. Based on the facility assessment: Establish guidelines for the adherence to Standard Precautions in the care of residents; Establish guidelines for adherence to Enhanced-Barrier Precautions in the care of residents, when applicable; Establish guidelines for implementing Transmission-Based Precautions, when necessary, based on the pathogen and circumstances of the illness/infection and to be the least restrictive possible for the resident under the circumstances; and Establish guidelines and practices for hand hygiene to be observed by healthcare personnel, residents and visitors.<br><br>The Policy and Procedure titled, Catheter Guidelines; Urinary, revised 9/11/2023, Infection Prevention and Control documented do not position catheter drainage bag touching the floor. A minimum of standard precautions followed when handling or manipulating the drainage System: Additional precautions (e.g., enhanced barrier, contact, droplet) will be followed based on the resident's plan of care and/or individualized needs; Provide routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering).<br><br>48744<br><br>Resident #17<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Resident #17 was admitted to the facility with diagnoses of anxiety disorder, paraplegia (inability to voluntarily move the lower parts of the body), and stage 4 pressure ulcer of buttock. The Minimum Data Set, dated dated dated [DATE] (an assessment tool), documented the resident was cognitively intact. The resident was able to make themselves understood and was able to understand others.<br><br>During an observation on 1/13/2025 at 1:53 PM, Resident #17 was in bed and the resident's urinary catheter drainage bag was exposed, lying on the floor.<br><br>Resident #218<br><br>Resident #218 was admitted to the facility with diagnoses of Chronic Obstructive Pulmonary Disease (an inflammatory disorder that causes muscle pain and stiffness); failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity); and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set, dated dated dated ,d+[DATE], documented the resident had no impaired cognition, could be understood or understand others.<br><br>During an observation on 1/13/2025 at 1:40 PM, Resident #218 was sitting in their room and there was no labeling on either oxygen tubing to their concentrator or portable oxygen bottle. Resident oxygen tubing from the concentrator was sitting on the floor of the resident's room.<br><br>During an interview on 1/13/2025 at 1:41 PM, Resident #218 stated staff never changed the tubing and rarely labelled it either.<br><br>51131<br><br>Resident # 364<br><br>Resident #364 was admitted to the facility with diagnoses of unspecified fall, influenza virus A and other acidosis (a condition where the body has too much acid in body fluids). A Minimum Data Set, dated dated dated [DATE] documented Resident #364 was cognitively intact, could be understood, and understand others.<br><br>During an observation on 1/13/2025 at 1:41 PM, Resident #364 had a urinary catheter in place connected to a bed bag. The urinary catheter bag was observed uncovered and lying on the floor.<br><br>A care plan titled risk for Multiple Drug-Resistant Organisms (MDRO) colonization/ infection related to indwelling urinary catheter dated 1/08/2025 documented goal of Resident #364 would remain free of Multiple Drug -Resistant Organism infection/colonization. Interventions included: Educate Resident, family and visitors on Enhanced Barrier Precautions; Enhanced barrier precautions: wear personal protective equipment (gown, gloves) when providing high contact activities at bedside including dressing, bathing/showering, transferring, changing bed linens, providing hygiene, changing briefs/assisting with toileting, device care and/or use, or wound care. May additionally wear face protection (e.g., goggles, face shield, face mask) if there is a risk of splash or spray or circulating respiratory viruses in the community; and Remove Personal Protective Equipment , perform hand hygiene and reapply necessary Personal Protective Equipment before caring for another resident.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Delmar Center for Rehabilitation and Nursing | 125 Rockefeller Road<br>Delmar, NY 12054 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 1/14/2025 at 1:47 PM, Resident #364 stated they had never had a nurse check their catheter until 1/14/2025 when the nurse came in the room, did not put on Personal Protective Equipment, and looked at the catheter underneath their brief. Resident #364 stated staff left a package of cleansing wipes on the bedside stand and told them to clean the catheter three times a day. Resident #364 stated they were not given education on how to clean the catheter and they had not had a shower since leaving the hospital on 1/08/2024. Resident #364 stated the Certified Nurse Aides and the nurses who had taken care of them had never worn a gown or a mask until 1/14/2025; and they only recalled seeing staff wearing masks and gloves on 1/14/2025.<br><br>During observations on 1/13/2025 at 11:00 AM, a Certified Nurse Aide did not perform hand hygiene, put on or take off personal protective equipment before entering or exiting Resident #83's room [ROOM NUMBER] times to retrieve supplies. Resident #83 was noted to be on enhanced barrier precautions, and the Certified Nurse Aide had provided personal care.<br><br>During an observation on 1/13/2025 at 11:31 AM, a shared bathroom was noted to have personal care items not labeled or designated as belonging to which resident in the shared room, including, but not limited to a denture cup, and wash basin.<br><br>During an observation on 1/13/2025 at 11:48 AM, a shared bathroom was noted to have personal care items not labeled or designated as belonging to which resident in the shared room, including, but not limited to 2 wash basins, and a bariatric bed pan.<br><br>During an observation on 1/13/2025 at 12:07 PM, a shared bathroom was noted to have personal care items not labeled or designated as belonging to which resident in the shared room, including, but not limited to a bed pan.<br><br>During an observation on 1/13/2025 at 12:07 PM, a Certified Nurse Aide did not perform hand hygiene, put on or take off personal protective equipment before entering a resident's room, who was on transmission-based precautions. Upon exiting the room, the Certified Nurse Aide was observed to not be wearing gloves, taking dirty towels and cups from the resident's room to the dirty utility room.<br><br>During an observation on 1/13/2025 at 12:09 PM, a Certified Nurse Aide was observed leaving the dirty utility room without completing hand hygiene and directly entered another resident's room.<br><br>During an observation on 1/13/2025 at 12:13 PM, a Certified Nurse Aide was observed entering a resident's room, who was on enhanced barrier precautions, and they did not complete hand hygiene or put on personal protective equipment.<br><br>During an observation on 1/13/2025 at 1:05 PM, a Certified Nurse Aide was observed providing incontinence care to a resident on transmission-based precautions. The Certified Nurse Aide did not put on or take off personal protective equipment or perform hand hygiene both before and after providing personal care to the resident.<br><br>During an observation on 1/22/2025 at 10:31 AM, Licensed Practical Nurse #6 on B Unit was observed wearing their N95 mask under their nose.<br><br>(continued on next page) |

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| | 335735 | A. Building<br>B. Wing | 01/23/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 1/15/2025 at 6:00 PM, Certified Nurse Aide #1 stated they needed to wear a gown, gloves and a mask when they entered a room with a Transmission Barrier Precaution or Enhanced Barrier Precaution sign. They stated that all Personal Protective Equipment was located on the resident's door. They stated they could go to the clean utility room and get more Personal Protective Equipment if it had been stocked. Certified Nurse Aide #1 stated that most aides only wore the Personal Protective Equipment when they were giving personal care to a resident, not if they were just answering the light or checking in on them.<br><br>During an interview on 01/17/2025 at 12:05 PM, Director of Nursing #1 stated that handwashing must be completed when staff entered the patient's room, exited the room, before and after care was provided and between passing trays and during meals. Director of Nursing #1 stated that Enhanced Barrier Precautions required a mask, gloves and gown; and Transmission Based Precautions required N95 mask, gloves, gown and face shield. They stated staff were trained in Standard Precautions and Enhanced Barrier Precautions/ Transmission Barrier Precautions education, and this was provided at hire, yearly, and as needed. Director of Nursing #1 stated when they saw a staff member not wearing Personal Protective Equipment or applying Personal Protective Equipment incorrectly, they had stopped and re-educated them by asking them what they had done incorrectly and then walked them through the process of putting on and taking off step by step. Director of Nursing #1 stated they did not complete this as a formal education and had not asked staff to sign off that they were re-educated. They stated they depended on their unit managers from 7 AM to 4:30 PM Monday through Friday to monitor the standard precautions and Registered Nurse supervisors to monitor for noncompliance on weekends and evenings. Director of Nursing #1 stated if someone was noted to be noncompliant on more than one occasion, they were in serviced and retrained and auditing would be done by someone. Director of Nursing #1 stated supplies were located in the central supply room and maintenance, or housekeeping restocked the carts and door containers when they were low. Hand sanitizers were located on the wall in dispensers and there are individual bottles of sanitizer located in the central supply room. Director of Nursing #1 stated employees were expected to put on and take off Personal Protective Equipment in the resident's room; staff were expected to carry linens and soiled clothing in a garbage bag.<br><br>10 New York Code of Rules and Regulations 483.80 (b) (1)-(4) (c) |

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| F 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>51131<br><br>Based on observation and interview during the recertification survey, the facility did not designate one or more individual(s) as Infection Preventionist (s) responsible for the facility's Infection Prevention Control Practices. Specifically, the facility did not have designated individual as their Infection Control Preventionist from October 4th 2024 to January 2025.<br><br>This is evidenced by:<br><br>Cross referenced to: F880 Infection Control<br><br>The Policy and Procedure titled C-IC-14 Antibiotic Stewardship created 10/2017 and revised 7/25/2024, documented under Accountability: The facility Infection Preventionist has oversight of the Antibiotic Stewardship , with input, review, guidance, and actions taken by the facility's Medical Director, Consultant Pharmacist, Director of Nurses, Administrator, and other facility leaders as appropriate; and The Medical Director, Consultant Pharmacist, Administrator, and Director of Nurses shall regularly participate in Infection Prevention and Control Committee/QAA meetings and provide feedback in regards to the Antibiotic Stewardship Program.<br><br>The policy further documented under Policy Implementation: Through oversight of the Quality Assessment and Assurance (QAA) Committee, the Infection Prevention and Control Committee (IPCC), shall oversee implementation of infection control policies and practices, and help department heads and managers implement infection prevention and control measures within their departments and, inquiries concerning infection control policies, procedures, and facility practices should be referred to the Infection Preventionist or Director of Nursing Services.<br><br>General observations during the entire recertification survey indicated insufficient infection control practices among the staff.<br><br>An interview conducted on 01/17/2025 at 12:05 PM, Director of Nursing #1 stated they were the current Infection Preventionist and the Nurse Educator. They stated there had not been anyone available to complete the Infection Preventionist role since they became the Director of Nursing role in October 2024. They stated they were the Nurse Educator in the facility as well as Infection Preventionist and Director of Nursing. They stated there was no way they could train and observe everyone in the facility.<br><br>10 New York Code of Rules and Regulations 483.80 (b) (1)-(4) (c) |