STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335759	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwich Rehabilitation & Nursing Center	88 Calvary Drive Norwich, NY 13815

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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 0584 Level of Harm - Minimal harm or potential for actual harm 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. Based on observations, record review, and interviews during the recertification and abbreviated (NY00353879) surveys conducted 7/29/2025-8/1/2025, the facility did not ensure a safe, comfortable, and homelike environment for two (2) of two (2) residents (Residents #39 and #80) reviewed and seven (7) anonymous residents present at the group meeting. Specifically, Resident #39's room and bathroom had a strong odor of urine; Resident #80 had missing clothing items and a wheelchair with a wheel in disrepair; and seven (7) anonymous residents reported they had items missing from laundry.Findings include:The facility policy Assistive Devices and Equipment, dated 2/2022 documented certain devices and equipment that assisted with resident mobility were provided for residents. In the event equipment was not functioning or was in poor repair, it was immediately removed from use and a replacement device implemented in a timely manner. The facility policy Quality of Life-Homelike Environment, dated 3/2022, documented the facility would reflect a personalized, homelike setting to include such characteristics as an orderly environment and pleasant, neutral scents; and management would minimize, to the extent possible, institutional odors.The facility policy Personal Belongings, revised 3/2023, documented a resident's personal belongings and clothing would be inventoried and documented upon admission and when such items were replenished.The facility policy Resident Clothing/Laundry and Labeling Procedure, revised 9/2024, documented resident clothing would be labeled and logged to prevent loss while in the facility and clothing should be labeled and returned to the unit within 72 hours of admission, re-admission, receipt. During an anonymous group meeting on 7/29/2025 at 2:10 PM, seven residents reported they had lost clothing. Clothing and washable items went missing even if labeled, and staff said they would look for it but did not follow through. 1) Resident #39 had diagnoses including diabetes. The 7/11/2025 Minimum Data Set assessment documented cognition was not assessed, the resident was frequently incontinence of urine and required moderate assistance with most activities of daily living. The 8/5/2024 Comprehensive Care Plan, revised 2/4/2025, documented the resident had frequent incontinence related to decreased mobility. Interventions included the resident would request assistance to the bathroom; change brief when incontinent and when needed; and change clothing as needed after incontinence episodes. The July 2025's Daily Housekeeping Completion Checklists documented the following:-Resident #39's bathroom received all disinfecting/cleaning tasks daily.-Resident #39's bedroom received all disinfecting/cleaning tasks daily except 7/14/2025, 7/20/2025 and 7/24/2025. -Resident #39's bathroom received a deep cleaning or multiple cleanings on 7/1/2025, 7/2/2025, 7/3/2025, 7/7/2025, 7/9/2025, 7/10/2025, 7/11/2025, 7/12/2025, 7/15/2025, 7/23/2025, 7/26/2025, 7/27/2025, and 7/30/2025.During an observation on 7/29/2025 at 11:31 AM Resident #39's room had a strong smell of urine and was strongest on Resident #39's side of the room.During an interview and observation on 7/30/2025 at 11:38 AM Resident #39's two family members stated they picked up dirty laundry three times a week. The dirty clothes were kept in a laundry basket located next to the resident's bed. The laundry was not in bags, so they brought their own bags to put the soiled clothing in to take home to wash. They noticed a smell as if the clothing was sitting a while. The resident stated when their dirty clothes were in the laundry basket and were (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not in a bag, the smell was not contained and was not pleasant. During an observation on 7/31/2025 at 9:41 AM, the resident's hamper was next to the head of the bed. The hamper was more than half-full of clothing and smelled of urine and was not in a plastic bag. During an observation on 8/1/2025 at 9:15 the resident's room smelled of urine and was stronger in the bathroom near the toilet. During an interview on 8/1/2025 at 9:18 AM, Certified Nurse Aide #17 stated if family did the laundry, dirty clothing was placed in a plastic bag in a laundry basket kept in their room. Resident #39's family did their laundry, and the hamper was kept in their room right next to their bed. The resident resisted toileting help, and would only asked for help if their clothing was wet and needed changing. They cleaned the floor as best they could and reported any concerns to housekeeping. During an interview on 8/1/2025 at 9:26 AM Housekeeper #16 stated they cleaned Resident #39's room first each day and often cleaned it multiple times a day due to the odor. Yesterday they used shaving cream on the bathroom floor, which helped. They had talked to their supervisor about it in the past.During an interview on 8/1/2025 at 9:30 AM, the Director of Environmental Services #3 stated they were made aware about 3 months ago that Resident #39's bathroom smelled of urine. They stated all they could do was keep cleaning it. They had not tried any other cleaning products as it would be too risky not knowing how the resident might react. 2) Resident #80 had diagnoses including congestive heart failure. The 7/11/2025 Minimum Data Set assessment documented the resident's cognition was intact, utilized a manual wheelchair, and required substantial assistance with wheelchair mobility. The 7/7/2025 Comprehensive Care Plan documented an activities of daily living self-care performance deficit and physical mobility limitation. Interventions included the resident required limited assistance for locomotion using a bariatric wheelchair.During an observation and interview on 7/29/2025 at 2:48 PM Resident #80 stated they could not steer their wheelchair as it was so stiff. They stated they were missing shorts. The shorts had labels, but they were in the laundry now. They stated their family did their laundry, but some items were sent to facility laundry and did not come back. There was a sign on the closet documenting the family would do laundry.During an observation and interview on 7/30/2025 at 9:59 AM, the resident was sitting in their wheelchair. The left wheel on their wheelchair was frayed and they could not steer. They stated they told several staff for a week or two and was told by two higher ups that it would be fixed, but it was not.During an interview on 7/30/2025 at 2:28 PM Certified Nurse Aide #12 stated if a resident's walker or wheelchair was broken, they told therapy. They had a hard time pushing Resident #80's wheelchair for over a week. They told therapy and nothing was done.During an interview on 7/31/2025 at 8:50 AM Certified Nurse Aide #7 stated Resident #80 was missing laundry. Sometimes evening staff sent their items to facility laundry even though there was a sign on the door stating family did their laundry. During an interview on 7/31/2025 at 1:22 PM Receptionist #10 stated one of their job duties was to label property. When there was a new admission, they documented all items on an inventory list and labeled clothing with a permanent marker on the tag of the clothing. The inventory list went into the medical records mailbox to be scanned into the system. Once inventoried, all items went to the resident's room. If family brought in a bag of items, they asked if they were bringing back laundry or if there were new items to be inventoried. They had been told by residents they were missing clothing and reported that to social worker and the unit manager. They worked until 3:00PM and someone else covered the desk from 3:00 PM - 7:00 PM. The facility did not get admissions after 7:00 PM. During an interview on 7/31/2025 at 4:08 PM Housekeeper Supervisor #11 stated all clothing items were labeled by the receptionist. They were unsure if that was documented anywhere. Items were washed, hung and delivered within 24 hours. They did get clothes without labels and if they did not know whose clothing they were, the clothing was hung on a rack. They had many blankets not labeled. Resident #80's family did their laundry, but they still saw the resident's items in laundry and had just labeled their shorts as they had to return them. During an interview on 7/31/2025 at 12:20 PM Physical Therapist #13 stated if someone had a broken wheelchair or walker one of the therapists should be told. They were not notified Resident #80's wheelchair was broken. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/1/2025 at 7:18 AM the Maintenance/Environmental Service Director #3 stated they had heard about residents and their missing clothing. If they could not find the missing items, they called family members to see if they were taken home and searched every closet until they found it. If they could not find the items, they notified the Administrator. Sometimes things did get put in the wrong closet. They never threw clothing away. If a walker or wheelchair was not working, maintenance or therapy were notified. They looked at Resident #80's wheelchair stated the rubber on the wheel needed to be replaced. During an interview on 8/1/2025 at 7:33 AM Occupational Therapist #14 stated their department made sure wheelchairs were in proper working order. If a wheel was broken, they would fix it. If a wheel was broken it could make it harder to self-propel. They were not aware Resident #80's wheelchair was not working. They looked at the wheelchair and stated the wheel was broken. They could not replace the rim but could replace the wheel if they had the part. During an interview on 8/1/2025 at 8:59 AM Registered Nurse Unit Manager #6 stated if a wheelchair was broken therapy should be notified. They did not know the wheel was broken.During an interview on 8/1/2025 at 12:23 PM the Director of Rehabilitation #4 stated they fixed broken wheelchairs and if they could not be fixed, they threw them away. It was important wheelchairs were functioning properly for safety, comfort, and mobility. If something could not be fixed or had to order parts they would get a temporary replacement. During a follow-up interview on 8/1/2025 at 1:59 PM the Director of Rehabilitation Services stated equipment was checked every 3 months to include brakes and cushions. Equipment should be checked by all staff. If a problem was noticed, they would fix it. No one noticed Resident #80's wheelchair it and it was not brought to their attention. 10 NYCRR 415.29(j)(1)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the recertification survey conducted 7/29/2025-8/1/2025 the facility did not develop and implement an effective discharge planning process that focused on the resident's discharge goals for two (2) of three (3) residents (Resident #1 and Resident #90). Specifically, there was no documented evidence of an ongoing discharge plan for Resident #1 and Resident #90.Findings include:The facility policy “Discharge Summary and Plan,” initiated 6/28/2025, documented when a resident's discharge is anticipated, a discharge plan will be developed. Every resident was evaluated for their discharge needs and would have an individualized post-discharge plan. The post-discharge plan was developed by the Care Planning/Interdisciplinary Team and included where the resident would reside, arrangements for follow-up care, resident's stated discharge goals, degree of caregiver/support person availability, capacity and capability to perform required care, factors that would make the resident vulnerable to preventable readmission and how those factors were addressed. The discharge plan was re-evaluated based on changed in the resident's condition or needs prior to discharge. The resident would be referred to local agencies and support services to assist in accommodating the resident's post-discharge preferences. 1) Resident #1 had diagnoses including cardiac arrest, coagulation defect, and atrial fibrillation (irregular heartbeat). The 7/1/2025 Minimum Data Set assessment documented the resident had intact cognition, required partial/moderate assistance with hygiene and oral care, and the discharge goal was a discharge back to the community. The 6/27/2025 Social Services Evaluation by Director of Social Services #9, documented Resident #1 was admitted for short term rehabilitation and active discharge planning was occurring for the resident to return to the community. The resident wished to be discharged back to their apartment where they lived alone. The 6/27/2025 physical therapy evaluation completed by Physical Therapy Assistant #20 documented Resident #1 required skilled physical therapy for gait training, facilitate functional mobility, promote safety awareness, improve dynamic balance, increase functional activity tolerance and increase lower extremity range of motion. The Comprehensive Care Plan initiated 7/2/2025, documented the resident wished to be discharged back to their apartment. Interventions included encouraging the resident to discuss feelings and concerns with impending discharge. The 7/27/2025 physical therapy evaluation completed by Physical Therapy Assistant #20 documented Resident #1 was ambulating 100 feet with a rolling walker and maintained standing balance without support against minimal resistance. There was no documented evidence of an ongoing assessment or re-evaluation of Resident #1's discharge goals. During an interview on 7/30/2025 at 10:26 AM, Resident #1 stated they were upset that they were functioning at their baseline and wanted to go back to their apartment. They were told by staff they could not be discharged because they required wound care for a facility acquired heel wound. They should be able to go home with homecare. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 8/01/2025 at 1:04 PM, Resident #1 was using a rolling walker independently to ambulate. The resident stated they were very upset and felt depressed as physical therapy said they were ready to go home. During an interview on 8/1/2025 at 7:33 AM, Occupational Therapist #14 stated they were working with Resident #1, the resident's therapy had progressed and met all their goals. They were ready for discharge. During an interview on 8/1/2025 at 8:59 AM, Registered Nurse Unit Manager #6 stated Resident #1 had a right heel wound that was improving and required daily dressing changes. The Unit Manager spoke to the Director of Social Services yesterday and when the frequency of the dressing changes goes down to every three days the resident would be able to go home. During an interview on 8/1/2025 at 1:08 PM, Director of Social Services #9 stated they were responsible for coordinating and documenting the discharge progress. They met with the resident approximately 10 days ago and discussed their physical therapy goals. The resident had aide services prior to admission through the county. The interdisciplinary team met about the resident's discharge on [DATE] and it was determined the resident could not be discharged until the dressing changes were every three days as Home Care was not able to accommodate daily dressing changes. They did not document any discharge plan for Resident #1 and should have. 2) Resident #90 had diagnoses including fracture of left femur and orthopedic aftercare. The 7/18/2025 Minimum Data Set documented the resident had moderately impaired cognition, required moderate to substantial assistance for activities of daily living and dependent for transfers and mobility, and no active discharge planning for the resident. The Comprehensive Care Plan, initiated on 7/18/2025, documented the resident wished to be discharged back to their apartment, where they lived alone. The discharge goal stated the resident will communicate an understanding of the discharge plan and describe the desired outcome. Interventions included to encourage the resident to discuss feelings and concerns with impending discharge and to monitor for and address episodes of anxiety, fear, and distress. The 7/18/2025 Social Services Evaluation by Director of Social Services #9, documented Resident #90 had been admitted for short term rehab. They wished to be discharged back to their apartment. The 7/22/2025 admission Provider note documented the resident was admitted for rehabilitation and strengthening. The resident was refusing rehabilitation and they had a lot of challenging issues trying to get them home safely. The 7/22/2025 Social Services note, Director of Social Services #9 documented the resident wanted to be discharged against medical advice. They explained the risks of discharge to the resident and informed them that they were free to make the decision to leave the facility. The resident called their daughter and was told that their daughter would not be picking them up and to stay to receive care and physical therapy. The resident stated they were adamant about leaving and informed staff that they would hurt themselves if they could not leave. Social Work contact the residents Health Care Proxy and informed them of the resident's statement. The Health Care Proxy stated they would not support the resident leaving. The resident independently contacted the authorities reporting chest pain and was transported to the hospital by ambulance. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/22/2025 Emergency Department Nurses Note documented nursing called family to pick resident up from the hospital. Resident's daughter refused to pick them up and bring them home stating the resident did not have anyone in the home to care for her. The resident denied and stated their neighbors would help them. The hospital contacted the rehab facility and was told the resident was dependent and unable to walk because of a femur fracture. The hospital made the decision to send the resident back to the rehab facility. There was no documented evidence of an ongoing assessment or re-evaluation of Resident #90's discharge goals. On 7/31/2025 at 9:42 AM, Resident stated they still wanted to leave against medical advice. No one brought discharge paperwork or helped with discharge; they felt like they were being held hostage. They wanted a referral placed for full time skilled nursing to assist at home and to have physical and occupational therapy referral placed to get services at home. They wanted to go home so badly that regardless of needs they would what they had to do to leave. During an interview on 7/31/2025 at 9:21 AM, Social Services Director #9 stated that discharge planning was to begin on admission. They recorded resident's goals and what they thought they needed to achieve that goal to go home; they then discussed this with the interdisciplinary team and physical therapy. They usually met with the care team weekly to discuss residents. Resident #90 was able to make their own decisions, and their goal was to go home and live independently. The resident's family had concerns about their ability to maintain a quality level of living; the resident disagreed. The Resident was unsafe to go home and perform day-to-day tasks and would require full time skilled nursing care in order to be discharged safely. They had not placed any referrals for at home physical or occupational therapy for the resident. They had also not placed any referrals for full time skilled nursing care. They had multiple conversations with the resident regarding safety in the home and what type of care would be required. Social Services Director #9 stated there was no documentation of conversations with the resident regarding discharge planning and safety. They did not have any discharge plan after the discussion of the resident wanting to leave the facility against medical advice. 10NYCRR 415.11(d)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, and record review during the recertification survey conducted 7/29/2025-8/1/2025, the facility did not develop and implement a comprehensive person-centered care plan for each resident to include services provided to maintain the resident's highest practicable physical well-being for one (1) of one (1) resident (Resident #1) reviewed. Specifically, Resident #1 did not have a care plan for managing anticoagulant therapy (blood thinner).Findings include:The undated facility policy Care Plan-Timing and Revision, documented a comprehensive care plan was developed for each resident within seven days and included measurable objectives and timeframes to meet the resident's physical, mental, and psychosocial well-being. Assessments of the resident were ongoing, and care plans were revised when information about the resident and their condition changed. The comprehensive care plan was reviewed and updated by the interdisciplinary team when there was a significant change in the resident's condition, at least quarterly, and when the resident had been readmitted to the facility from a hospital stay. Resident #1 had diagnoses including cardiac arrest, coagulation defect, and atrial fibrillation (irregular heartbeat). The 7/1/2025 Minimum Data Set assessment documented the resident had intact cognition and received an anticoagulant. The 6/27/2025 physician order documented Eliquis (blood thinner) 5 milligrams twice a day for atrial fibrillation. The Comprehensive Care Plan initiated 6/27/2025 documented the resident had a pacemaker (electronic device implanted in the chest to regulate heartbeat) related to atrial fibrillation. Interventions included monitoring for malfunction and pulse lower than programmed rate. The Comprehensive Care Plan did not include use of an anticoagulant (blood thinner) or monitoring for bleeding precautions. During an interview on 7/31/2025 at 8:50 AM, Certified Nurse Aide #7 stated they were not sure if anticoagulant therapy should be in the resident's care plan but would like to know to monitor for bleeding when they shaved the resident. During an interview on 8/1/2025 at 8:37 AM, Licensed Practical Nurse #8 stated care plans were completed by the Registered Nurse Unit Managers along with department heads from social work, physical therapy, and activities. Anticoagulant therapy should be documented on the care plan so staff could monitor for bleeding precautions. Resident #1 was on an anticoagulant and should be monitored for bleeding. During an interview on 8/01/2025 at 8:59 AM, Registered Nurse Unit Manager #6 stated Resident #1 was on an anticoagulant administered and monitored by nursing staff. They were unaware it was not in the resident's care plan but thought it should be, so staff knew to monitor for bleeding. Care plans were completed by physical therapy, the infection control nurse, social work, activities, and Registered Nurse Unit Managers. Everything was manually added into the care plan. They referred to the resident's care plan and stated there was no documentation regarding anticoagulant therapy. 10NYCRR 415.11(c)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interview during the recertification survey conducted 7/29/20225-8/1/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for one (1) of four (4) residents (Resident #3) reviewed. Specifically, Resident #3 had a significant weight loss, weekly weights were not completed as ordered, the medical providers were not notified of the weight loss and the resident had a functional decline in their eating ability and a referral for an occupational therapy evaluation was not submitted timely. Findings include:The facility policy, Weights, effective 3/2024, documented monthly weights were completed by the 7th of each month and weekly weights were distributed on Tuesdays and completed by end of day on Wednesday. The dietician was responsible to ensure weights were evaluated and notify the nurse manager to verify any weight variance of 5 pounds or more by immediate reweight. The dietician notified the nurse manager, medical doctor, and care plan team with any significant weight variance. Any variance of 5 percent in 30 days triggered the attending physician and responsible party was informed of the weight variance by the nurse manager or dietician and the same was documented in the resident's medical chart in the appropriate disciplines section. The facility policy, Nutrition (Impaired)/ Unplanned Weight Loss, effective 5/2025 documented nursing staff monitored and documented weight and dietary intake of residents. Five percent weight loss in a month was significant and greater than five percent was severe. The physician with the help of the multidisciplinary team identified conditions that may be causing weight loss such as a functional decline. Resident #3 had diagnoses including dementia, chronic kidney disease and heart failure. The 6/9/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, required supervision for eating, did not have weight loss and was on a mechanically altered diet.The Comprehensive Care Plan initiated 5/31/2024, and revised 5/22/2025 documented the resident had a nutritional problem and activity of daily living self-care performance deficit. Interventions included set up with meals, intake was monitored and recorded, supplements were provided as ordered, and weights were obtained per policy. The 4/28/2025 physician order documented weekly weights on Mondays. There was no documented evidence the resident's weights were obtained weekly from 4/28/2025-8/1/2025. The resident's documented monthly weights were, 224 pounds on 5/8/2025, 222.4 pounds on 6/3/2025 and 202 pounds (9.2 percent loss) on 7/1/2025. There was no documented evidence the 7/1/2025 weight was verified for Resident #3. The 7/14/2025 Registered Dietician progress note documented a weight decline of 20.4 pounds, a 9.2 percent weight loss in the past month was determined accurate. Meal intake ranged from 25 percent to 100 percent. Recommended changes included increasing the 2 calorie/milliliter supplement to four times a day and continued weekly weights as ordered. There was in no documented evidence the medical providers were notified of the resident's weight loss. On 7/27/2025, the Medical Director documented the resident was seen for a 60-day follow up visit. The Physical Exam noted a weight of 202 pounds and the Assessment and Plan did not include documentation related to Resident #3's weight loss. The July 2025 Activity of Daily Living Certified Nurse Aide Documentation included the resident required limited or extensive (more than set up) assistance with eating for:Breakfast meals on 7/9/2025, 7/12/2025, 7/14/2025, 7/19/2025, 7/25/2025, and 7/31/2025.Lunch meals on 7/4/2025, 7/9/2025, 7/11/2025, and 7/18/2025.Dinner meals on 7/9/2025, 7/10/2025, 7/12/2025, 7/15/2025, 7/18/2025, 7/20/2025-7/24/2025, 7/26/2025, 7/28/2025 (dependent), and 7/30/2025.During an observation on 7/30/2025 at 12:56 PM, Resident #3 was seated in their wheelchair at a table in the dining room. The resident had not eaten anything on their lunch tray but was drinking from their coffee mug. At 1:07 PM, the resident picked up their bread and ate it. At 1:23 PM the resident attempted to get their ziti and their green beans onto their fork but unable to do so. At 1:38 PM, they used their hands to attempt to get the ziti onto their fork. At 1:48 PM, Resident #3 was the only resident remaining in the dining room and observed picking up the ziti pasta with their hands and put it in a bowl. They were eating (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ziti out of the bowl with a plastic spoon. Licensed Practical Nurse #23 was still present in the dining room. Staff did not provide any assistance to Resident #3 during the lunch meal. During an observation on 7/31/2025 at 8:45 AM, the resident was seated in their wheelchair at a table in the dining room for the breakfast meal. Occupational Therapist #25 sat with them while they ate. At 9:09 AM, the resident's food was moved to a scoop plate, the resident was given a weighted spoon, and a straw was placed in their prune juice. At 9:20 AM, Occupational Therapist #25 stated that the resident definitely needed more help with feeding and stated the scoop plate and the straws made a big difference in the resident's ability. The weighted spoon did not seem to make any difference. At 12:52 PM, Certified Nurse Aide #17 was sitting with the resident in the dining room for the lunch meal. They asked Licensed Practical Nurse #24 if they could assist a different resident because Resident #3 was eating independently with the scoop plate and a spoon. The 7/31/2025 Occupational Therapy evaluation by Occupational Therapist #25 documented a clinical impression that the resident required assistance with self-feeding at this time. Further skilled services were required to assess adaptations, improve thoroughness and attention, and the goal was increased intake. There was no documented evidence of an evaluation by Occupational Therapy prior to 7/31/2025. During an interview on 7/31/2025 at 1:19 PM, Certified Nurse Aide #17 stated Resident #3 used to eat independently but required cueing. Recently, often the resident's food just fell off the plate. The resident had needed more help over the past couple of months and they had to change their table location so they would be close enough to provide cueing. There was not enough staff to assist the resident's normally, and they often fed three residents at the same time. They reported the resident's increased difficulty in the past couple of months but there was a lot of turn over and they were not sure who they reported it to. The resident had lost weight because their clothes used to fit and now, they were big. They had not reported the noticeable weight loss. Weekly weights were printed and posted on Mondays, they did not know if the resident was a weekly weight. They were happy the resident was finally evaluated by occupational therapy and could eat independently again. During an interview on 8/1/2025 at 9:13 AM, Licensed Practical Nurse Unit Manager #15 stated the certified nurse aides reported weight loss and then a resident was reweighed. It was then reported to the dietician and the doctor. If the dietician put the resident on weekly weights, they were on a list that was emailed every Monday. Resident #3 lost weight because they had a decrease in appetite. There was a noticeable decline in the past couple of weeks and at times the staff had to feed the resident. They referenced the electronic medical record and did not know why the resident's weekly weights were not being completed as ordered. They looked at their emails and confirmed Resident #3 had been listed on the weekly email from the Registered Dietician as a weekly weight. They were also listed as a reweight. They were responsible to ensure weights were completed as ordered. They were also responsible to update medical of the significant weight loss and it was documented in a note. They did not notify medical of the weight loss, but they should have. During a telephone interview on 8/1/2025 at 10:53 AM, the Registered Dietician stated they reviewed weights three times a week. They expected weekly weights were completed as ordered and sent out an email every Monday with the weights that needed to be completed. The weights were part of the equation to determine nutritional needs. They requested a reweight on Resident #3 because of a 20-pound weight loss. They were still waiting on a reweight since 7/1/2025. Reweights were due by the 10th of the month. They did not notice that weekly weights had not been completed as ordered but did have the resident listed as a weekly weight on the weekly emails. They did not have verbal conversations with the unit managers, they just included them in the weekly email communication and expected that was followed. Nursing was responsible to notify them and the medical provider of weight loss per the facility policy. If the resident had a functional decline, nursing was responsible therapy was made aware for a proper assessment. During a telephone interview on 8/1/2025 at 11:57 AM, Licensed Practical Nurse #23 stated they work the evening shift. They came in early on 7/30/2025 at the facility's request. Certified nurse aides were expected to report a resident's functional decline. They (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335759	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwich Rehabilitation & Nursing Center	88 Calvary Drive Norwich, NY 13815

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not made aware of any decline in Resident #3 but did put a referral in for therapy on 7/30/2025 because the resident seemed to only be able to feed themselves with the use of a bowl.During a telephone interview on 8/1/2025 at 12:40 PM, the Medical Director stated weights were expected to be obtained correctly and timely. If there was a weight loss, they looked for a dietary note, looked at historical weights, and evaluated if it was an expected loss or not. They had not been notified of Resident #3's 20 pound/ 9 percent weight loss in the past month. If the resident had a decline in the ability to feed themselves, they expected the nursing team put in a therapy evaluation. The weight loss needed an explanation and therefore the medical team needed to be involved.10NYCRR 415.12(i)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the recertification survey conducted 7/29/2025-8/1/2025, the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 was observed with a continuous positive airway pressure machine, and the medical record did not include a physician order or a care plan related to the use of the continuous positive airway pressure machine. Findings include:The facility policy CPAP/BIPAP (continuous positive airway pressure/bilevel positive airway pressure) effective 5/2022 documented CPAP/BIPAP (continuous positive airway pressure/bilevel positive airway pressure) was used in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease to promote comfort and safety. The machine was cleaned weekly with soap and water and the mask and tubing were cleaned daily with warm, soapy water and documented in the resident's medical record. The facility policy Oxygen Therapy-Medical Gases and their Cylinders, effective 2/2022 documented oxygen therapy was delivered by way of an oxygen mask or nasal canula using a portable oxygen cylinder or oxygen concentrator and must be verified by a physician order. 1)Resident #1 was admitted to the facility with diagnoses including obstructive sleep apnea, acute respiratory failure with hypoxia (low level of oxygen in the blood), and heart failure. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had intact cognition, required assistance of one for most activities of daily living, had a diagnosis including respiratory failure, and did not use continuous positive airway pressure/bilevel positive airway pressure therapy. The 6/27/2025 hospital transfer note documented Resident #1 used a continuous positive airway pressure machine. Resident #1 did not have a physician order for a continuous positive airway pressure machine and the comprehensive care plan initiated 6/27/25 and revised on 7/15/2025 did not include the use of a continuous positive airway pressure machine. The undated resident care instructions did not include use of a continuous positive airway pressure machine. During an observation and interview on 7/30/2025 at 10:26 AM, Resident #1 was observed to have a continuous positive airway pressure machine at their bedside. The resident stated they used the machine every night prior to admission and continued using it every night at the facility because they stopped breathing at night. Staff had not assisted them with cleaning the machine and they had to ask staff for the distilled water the machine required.During an observation and interview on 7/30/2025 at 10:23 AM, Certified Nurse Aide #12 was observed bringing a graduated cylinder of water to Resident #1. Resident #1 had a continuous positive airway pressure machine that they used every night and the resident asked them for distilled water for the machine. During an interview on 8/1/2025 at 8:37 AM, Licensed Practical Nurse #8 stated the use of a continuous positive airway pressure machine required a physician order and was documented on the care plan and treatment administration record. The treatment administration record would include the day of the week to clean the machine. The Registered Nurse Unit Managers were responsible for documenting the nursing section of the individual care plans and for updating them. During an interview on 8/01/2025 at 8:59 AM, Registered Nurse Unit Manager #6 stated a physician's order was required for a continuous positive airway pressure machine. They stated an order for a continuous positive airway pressure machine created a template that automatically populated on the treatment administration record so the nurse would know when to clean the machine. Registered nurses were responsible for completing the nursing section of the care plan initiating and updating them quarterly, annually, and as needed. Resident #1 was admitted to the facility with a continuous positive airway pressure machine. The admission nurse was responsible for notifying the physician to obtain an order for both treatments. There were a lot of admissions and discharges so it was possible for things to get missed.10 NYCRR 415.12(k)(6)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interview during the recertification survey, the facility did not ensure the provision of food and drink was palatable, attractive, and at a safe and appetizing temperature for 1 of 2 meal trays tested. Specifically, food was not served at palatable and safe temperatures.Findings include:The facility policy Food and Nutrition Services, revised 3/2023, documented each resident would be provided with a nourishing, palatable, well-balanced diet and food and nutrition staff would inspect food trays to ensure the food appeared palatable, attractive and served at a safe and appetizing temperature.The 8/12/2020 facility policy Heating Foods and Beverages in the Microwave documented methods would be established for the safe heating of foods and beverages in the microwave to limit the risk of food borne illness and serving foods and beverages safe for residents to handle; foods would be heated to a temperature of at least 165 degrees Fahrenheit and allow to stand covered for 2 minutes after obtaining temperature equilibrium; and food would not be served unless the temperature was less than or equal to the recommended temperature. Resident #78's 7/31/2025 lunch meal ticket documented 8 ounces of water, 8 ounces of coffee, 4 ounces of milk, 3 ounces of baked chicken, oven browned potatoes 1/2 cup, seasoned beets 1/2 cup, canned fruit 1/2 cup, pears with graham cream 4 ounces. During an observation on 7/31/2025 at 12:48 PM with Licensed Practical Nurse #27, Resident #78's lunch meal was tested for temperature, and palatability. The resident was provided with a replacement tray. The chicken lacked flavor, was tough to cut and measured 114 degrees Fahrenheit; potatoes measured 112 degrees Fahrenheit; and the beets tasted cold and measured 106.5 degrees Fahrenheit.During an observation on 7/29/2025 at 12:43 PM Dietary Aide #28 put cream of chicken soup in the microwave for one minute, removed it and obtained a temperature 130 degrees Fahrenheit. They then served the soup. During an interview on 7/29/2025 at 2:10 PM Resident #8 stated the food was tasteless and soup was warm. During a telephone interview on 8/1/2025 at 10:31 AM, Dietary Aide #28 stated they warmed the cream of chicken soup in the microwave but was unsure for how long and could not remember what temperature they obtained. They thought 130 degrees Fahrenheit for the soup was not hot enough. They should have put the soup back in the microwave and then taken another temperature until it was 135 degrees Fahrenheit or higher.During an interview on 8/1/2025 at 1:40 PM, the Food Services Director stated hot food should be served at 165-180 degrees Fahrenheit and cold food under 38 degrees Fahrenheit. The temperatures obtained on the test tray were not hot enough. There was a microwave policy on the units that states to start at a minute, swirl, take a temperature, swirl, put back in the microwave, recheck the temperature until heated to 165 degrees Fahrenheit. If a temperature of 130 degrees Fahrenheit was obtained, it should have been put back in until a temperature of 165 degrees Fahrenheit was achieved. Dietary staff should know the correct temperatures. 10NYCRR 415.14(d)(1)(2)