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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER: Iroquois Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 4600 Southwood Heights Drive Jamesville, NY 13078	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 46276 Based on observation, record review, and interview during the recertification survey conducted 8/14/2024 -8/20/2024, the facility did not ensure a safe, clean, comfortable, and homelike environment for 1 of 4 resident floors (Unit 1) reviewed. Specifically, Unit 1 had multiple unclean and damaged wheelchairs, positioning chairs, and positioning devices. Findings include: The facility policy, Devices and Equipment, dated 3/2028 documented all resident devices and equipment, to include wheelchairs and walkers, would be maintained on a schedule. Defective or worn devices would be repaired or replaced. The undated facility policy, Work Orders, documented all staff were responsible for submitting work orders in the electronic system and then it was to be forwarded to the maintenance director. The Director of Maintenance was responsible to ensure the work was completed in a timely manner. The following observations were made: - on 8/14/2024 at 10:06 AM, Resident #10 was sitting in a positioning chair in their room. The chair's arm rests were unclean, and the material on the right back side of the chair was ripped. - on 8/14/2024 at 10:11 AM, Resident #61 was sitting in a positioning chair in their room. Both armrests on the chair were unclean. - on 8/14/2024 at 10:52 AM, Resident #117 was sitting in a positioning chair in their room. The left, blue positioning wedge was ripped in several areas. - on 8/14/2024 at 11:00 AM, Resident #89 was sitting in a positioning chair in the unit common area. The chair's backrest was ripped on the side. - on 8/14/2024 at 11:01 AM, Resident #29 was sitting in a high-back wheelchair in the unit common area. The right arm rest had brown tape over it and the left arm rest had visible worn and soiled black foam. (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	- on 8/14/2024 at 11:11 AM, Resident #119 was sitting in a positioning chair. The left, back side of the chair was ripped. During an interview on 8/19/2024 at 10:17 AM, Certified Nurse Aide #2 stated all unit staff were responsible for cleaning resident chairs. Housekeeping also assisted with cleaning. Any staff member was able to put in a work order. If a chair was observed to be in disrepair, maintenance was notified, and the issue was usually fixed quickly. Therapy was responsible for replacing chairs if they were broken. Resident #29's chair should not have been in the condition it was. During an interview on 8/19/2024 at 11:22 AM, Licensed Practical Nurse Manager #3 stated all unit staff were responsible for cleaning wheelchairs and positioning chairs. All staff were responsible for submitting a work order to maintenance for any chairs needing repairs. They were not aware of any recently submitted work orders for chairs. They expected staff to notify them if a chair was ripped or needed repair. If a chair was unable to be fixed by maintenance, therapy would re-issue the resident a new chair. During an interview on 8/20/2024 at 9:56 AM, the Director of Nursing stated all staff were responsible for submitting an electronic work order for any equipment needing repair to the maintenance department. They were unaware of any chairs needing repair as they were checked frequently, and most were recently cleaned. Any chairs needing cleaning or in disrepair were not considered homelike, especially those that were ripped or torn. During an interview on 8/20/2024 at 10:59 AM, the Director of Maintenance stated their department was responsible for overseeing all work orders. All staff were responsible for submitting a work order for repairs. Once the work order was received, they usually had it repaired the same day. They had not received any work orders for Unit 1 chairs. They were not aware some of the chairs were ripped. The goal was for the facility to provide a homelike environment to all residents. 10 NYCRR 415.29(b)(j)(1)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 46276 Based on observations, record review, and interviews during the recertification survey conducted 8/14/2024 - 8/20/2024, the facility did not ensure indicated restraints were used for the least amount of time and documented ongoing re-evaluation of the need for restraints for 1 of 2 residents (Resident #7) reviewed. Specifically, Resident #7 had an order for a Merry [NAME] (an enclosed frame wheeled walker) that was evaluated as a restraint and the Comprehensive Care Plan did not address parameters of use for the Merry Walker; and the restraint assessment was incomplete. Findings include: The facility policy, Restraint Policy, revised 2/2021 documented all residents who required the use of a restraint would have a care plan developed. All care plans would be updated quarterly at a minimum. All restraints were to be released at least every 2 hours to allow the resident to exercise and change position. A specific physicians' order was to be entered in the residents' medical record which identified the medical symptom related to the restraint, type of restraint and parameters of use. It was not necessary to indicate restraint release every 2 hours as this was the facility guidelines for all restraints. Devices that had the potential to be considered physical restraints and required an evaluation included seat belts, scoot chairs and Merry Walkers. Resident #7 had diagnoses including dementia with anxiety. The 6/20/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, wandered daily, was independent with walking, sitting to standing, and transfers, and did not use restraints. The 3/7/2024 at 6:42 AM Physical Therapy evaluation completed by the Director of Rehabilitation documented the resident required evaluation due to a recent fall on the unit. Recommendations were to trial a Merry [NAME] to increase independence within the facility and for safety on the unit. A 3/7/2024 Director of Rehabilitation progress note documented the resident was trialing a Merry [NAME] on the unit to address falls. The resident required moderate assistance of 1 getting in the walker due to resistive behaviors. A 3/7/2024 at 2:50 PM Licensed Practical Nurse Unit Manager #3 progress note documented the resident was evaluated after a fall and a Merry [NAME] was trialed during physical therapy sessions only for safe ambulation. The 3/14/2024 and 3/27/2024 restraint assessments completed by Assistant Director of Nursing #14 documented the assessment was necessary to determine if the restraint was or continued to be an appropriate intervention. A risk versus benefits discussion was done, the resident had a Merry [NAME] that was currently the least restrictive measure, the family representative was educated, and a restraint continued to be appropriate. The eventual goal was independent ambulation. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/27/2024 Physician #10 order documented a Merry [NAME] for independent ambulation due to muscular weakness and difficulty walking. A 3/27/2024 at 3:33 PM Licensed Practical Nurse Unit Manager #3 progress note documented the resident had been trialing the use of a Merry [NAME] with therapy on the unit for safe independent ambulation. Therapy recommended the use of the Merry [NAME] on the unit independently for morning only at that time. The resident would continue to work with therapy to increase tolerance. The resident's family was aware. The 3/27/2024 nursing care instructions documented the resident's ambulation was changed to ambulation with a Merry [NAME] in the AM only. The Comprehensive Care Plan initiated 3/27/2024 documented the resident required a Merry [NAME] secondary to a diagnosis of dementia with poor safety awareness, muscle weakness, and frequent falls. Interventions included ensure proper trunk and body alignment, and physical and occupational therapy evaluations and treatments as needed. The care plan did not include parameters for the least restrictive use or least restrictive time for the restraint to be used. The 5/10/2024 nursing care instructions documented ambulation in the Merry [NAME] for safety. The 6/13/2024 quarterly restraint assessment completed by Assistant Director of Nursing #14 documented the resident used a Merry Walker, was unable to rise from the device but could rise from other seating devices, and the Merry [NAME] was considered a restraint. The assessment did not document restraint use or restraint use conclusion if the restraint was indicated. The resident was observed at the following times: - on 8/14/2024 at 11:02 AM sitting in the Merry Walker. The device enclosed the resident while they sat on the seat and there was a latch lock on the front of the cross bar. - on 8/16/2024 from 9:00 AM - 1:22 PM the resident was observed during a continuously. At 9:00 AM, sitting at a dining room table eating breakfast. At 9:13 AM Certified Nurse Aide #1 assisted the resident into the Merry [NAME] after breakfast. Certified Nurse Aide #1 stated they thought the Merry [NAME] was used to assist the resident with walking. They stated the resident could not release the restraint. Certified Nurse Aide #1 demonstrated how to release the front bar and seatbelt. They asked the resident if they could release the front bar of the walker and the resident did not reply. At 10:54 AM ambulating in the hall in the Merry Walker. From 11:41 AM-12:26 PM, sitting on the seat of the Merry [NAME] in the hall across from the dining room. At 12:27 PM transported by staff in the Merry [NAME] to the dining room. At 12:37 PM removed from the Merry [NAME] by staff and placed at the dining room table for lunch. - At 1:22 PM, placed back into the Merry [NAME] by staff after lunch was completed. During an interview on 8/19/2024 at 10:25 AM, Certified Nurse Aide #2 stated the resident used to walk around independently daily and wandered all over the unit but had a couple of falls and now they used a Merry Walker. The resident currently had a hard time standing up from the walker. They did not document when the Merry [NAME] was released because there was no place to document on the resident care instructions. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 11:22 AM Licensed Practical Nurse Unit Manager #3 stated the resident walked independently, had falls and required a Merry Walker. The resident had a physician order for the restraint, there were no parameters for use, the care plan did not list interventions, and the resident care instructions had no place for the certified nurse aides to document when it was released. During an interview on 8/19/2024 at 3:08 PM Resident #7's family representative stated they were informed by physical therapy a Merry [NAME] was needed to prevent falls as the resident would not remember to use a regular walker. The resident had two recent falls with no significant injuries and used to walk the halls independently. The resident could not release themself from the Merry [NAME] and they were concerned in the event of an emergency that it would not be safe for the resident to be in the Merry Walker. During an interview on 8/20/2024 at 9:27 AM the Director of Rehabilitation stated the resident had an evaluation on 3/7/2024 after a fall and was trialed with a Merry [NAME] to be used in the AM only. The Director of Rehabilitation stated when the resident was discharged from therapy on 5/10/2024 they changed the recommendation for the resident to use the Merry [NAME] at all times. They did not specifically document to release the Merry [NAME] every two hours. It would not be appropriate if the resident was not released after two hours. The risk could be skin breakdown and/or physical decline. During an interview on 8/20/2024 at 10:28 PM Nurse Practitioner #7 stated Merry Walkers were prescribed for a resident that had trialed all other assistive devices, had falls and continued to be injured. Resident #7 had a Merry Walker, could not release it themself, and it should be released every two hours. A physician order should document parameters for the least restrictive use and time for a resident who was unable to release the restraint themself. The risk of a resident not released from a restraint could result in skin breakdown or infection. During an interview on 8/20/2024 at 11:30 AM, the Administrator stated a restraint was any device that restrained or restricted a resident. Any restraint required a physician order, and it was the standard of care per their restraint policy to include the least restrictive use and time. Resident #7 had a Merry Walker, it was considered a restraint, and the resident could not release it themself. 10NYCRR 415.4(a)(2-7)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46276 Based on observation, record review, and interview during the recertification and abbreviated (NY00318948 and NY00314795) surveys conducted 8/14/2024-8/20/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 4 residents (Resident #36) reviewed. Specifically, Resident #36 was not assisted with timely toileting. Findings include: The undated facility policy, Certified Nurse Aide Activities of Daily Living, documented the certified nurse aide who completed the resident care was responsible for documenting the level of care the resident received that shift. The undated facility policy, Toileting Schedule, documented an incontinent resident would be placed on a toileting schedule. The resident was to be toileted a minimum of 5 times within a 24-hour period and must be documented. A sign was hung on the resident's bathroom door to serve as a reminder. The resident who required supervision for bowel function was to be taken to the toilet every 2 hours as part of the bladder program. Resident #36 had diagnoses including Alzheimer's dementia and anxiety. The 5/30/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, used a wheelchair, was dependent for toileting hygiene, toilet transfers, and wheelchair mobility, was frequently incontinent of urine and always incontinent of stool, and was not on a toileting program. The undated care instructions documented the resident required 2-person physical assistance and was dependent for toileting and was to wear incontinence briefs. The resident was to be toileted every day from 12:00 AM - 6:00 AM, 8:00 AM - 2:00 PM, and 4:00 PM - 10:00 PM. The 6/12/2024 Comprehensive Care Plan documented the resident had urinary incontinence, a history of urinary tract infections, was at risk for falls, and was at risk for impaired skin integrity. Interventions included offer toileting every 2-3 hours or check and change every 2 - 3 hours, promote good hygiene practices, keep free from moisture, provide with appropriate incontinence products, and increase toileting. During an observation on 8/15/2024 at 9:07 AM, an undated sign on a wall in the nursing office documented every resident was to be toileted per their care plan and not just once per shift. During a continuous observation on 8/16/2024 from 8:59 AM-12:38 PM, Resident #36 was observed: - at 8:59 AM seated in a positioning chair in the unit dining room eating breakfast. - at 9:53 AM, being moved to the back common area TV room for a church service. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 11:37 AM, being approached by Certified Nurse Aide #22 who asked the resident if they wanted to be moved to their assigned lunch table. Certified Nurse Aide #22 transported the resident back to the dining room table. At 12:38 PM the resident remained seated at the dining room table - at 1:22 PM, the resident remained sitting in their positioning chair in the unit dining room. At 1:25 PM they were transported to their room by Unit Aide #23. The resident was not toileted, and the last documented toileting had been signed for at 5:50 AM. During an interview on 8/16/2024 at 1:43 PM, Certified Nurse Aide #22 stated they documented provision of resident care two times during their shift: before lunch and before the end of their shift. Residents should be toileted at least 3 times a day. Most residents were toileted every 2 hours. Resident-specific care was documented in each resident's care instructions. Resident #36 required transfers by 2 with a mechanical lift. They stated they had not toileted the resident today. Depending on staffing for the shift, there were times the residents did not get toileted as often as they should, and the documentation was not always done. The 8/16/2024 toileting task for Resident #36 documented the resident was toileted by Certified Nurse Aide #22 at 2:20 PM. During an interview on 8/19/2024 at 11:22 AM, Licensed Practical Nurse Manager #3 stated unit staff were expected to toilet each resident before meals, after meals, and as needed. Cognitive residents were toileted as requested. Unit staff were expected to document resident care directly after the care was performed. Resident #36 required transferring by mechanical lift with 2 staff. They were responsible for overseeing that resident care was provided. If documentation was not done, it was assumed the care was not provided. The risk of not toileting a resident as planned was the resident could have skin breakdown in the perineal area. Resident #36 should be toileted as planned as they were at risk for skin breakdown. During an interview on 8/20/2024 at 9:56 AM, the Director of Nursing stated Resident #36 required substantial/maximum assistance with toileting; could stand and pivot and did not use a mechanical lift. They stated if the resident was not toileted per their care plan it would not be appropriate and could result in skin breakdown and/or infections. 10NYCRR 415.12(a)(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 33421 Based on observation, record review, and interview during the recertification survey conducted 8/14/2024 -8/20/2024, the facility did not ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for 1 of 1 resident (Resident #22) reviewed. Specifically, Resident #22 was not evaluated by therapy or care planned for the use of a scoot chair (a low-to-the-ground positioning chair that allows self-propulsion by foot and reduces the risk of falls). Findings include: The facility policy, Devices and Equipment, dated 3/2018 documented recommendations for devices, which included wheelchairs, were to be documented in the residents' plans of care. Nursing would request therapy services to evaluate a device that was not properly fitting. The undated facility policy, Comprehensive Care Planning, documented the interdisciplinary team would review the care plan with a significant change and as needed. The care plan would be individualized for each resident. Changes that resulted in a different approach must be documented in the care plan. The undated facility policy, Therapy Screenings and Referral Procedure, documented residents who had a change in status would receive a referral from nursing, recommended for a therapy evaluation, and treated as indicated. Resident #22 had diagnoses including dementia, fracture of the right femur (thigh bone), and right hip replacement. The 5/22/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, used a manual wheelchair, had impairment of one leg, required supervision to moderate assistance with transfers, was dependent for wheelchair mobility, and received physical and occupational therapy. The resident was unable to attempt walking due to medical condition or safety concerns with a discharge goal of walking 150 feet independently. The 5/16/2024 comprehensive care plan documented the resident had an alteration in activities of daily living, had a history of falls (last fall 7/27/2024), and had dementia. The plan included maintenance of levels for bed mobility, transfers, locomotion, and ambulation as possible. Interventions included hip precautions (used to avoid extra stress on the hip joint), maximum assistance of 1 with bed mobility/sitting/lying, maximum assistance of 2 for transfers, manual wheelchair with pressure-relieving cushion, bilateral anti-rollbacks on wheelchair, bilateral wheelchair leg rests, and physical and/or occupational evaluation as needed. The care plan did not document the use of a scoot chair. The 5/16/2024 at 12:33 PM Registered Nurse #13 admission progress note documented the resident had a diagnosis of left hip fracture with replacement. The resident required maximum assistance of 1 for transfers and used a wheelchair. The 5/16/2024 Physician #10 order documented weight bearing as tolerated on right lower leg. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/17/2024 Physician #10 order documented posterior hip precautions. The 5/20/2024 at 4:16 PM Licensed Practical Nurse #3 progress note documented therapy issued the resident a wheelchair pommel cushion (a positioning cushion for the seat) for positioning in their wheelchair. The 6/24/2024 at 2:32 PM Director of Nursing progress note documented the resident was assessed for wheelchair positioning to ensure they were in the proper wheelchair. The 6/28/2024 through 7/10/2024 physical therapy notes did not document the use of a scoot chair. The 7/1/2024 Director of Therapy progress note documented the resident was provided with a new 16-inch regular wheelchair with a gel seat cushion and leg rests. The 7/10/2024 Physical Therapist #16 progress note documented the resident received leg stretches to improve positioning in their wheelchair. The 7/26/2024 Registered Nurse #18 restraint assessment documented the resident had a positioning chair with a matrix cushion (a seat cushion for fragile skin), was unable to rise from the device, and could not rise from any seating device. The positioning chair was not considered a restraint. The 7/31/2024 Physician #10 order documented occupational therapy evaluation and treat 5 times a week for 4 weeks to include wheelchair assessment and management. The 8/14/2024 through 8/18/2024 care instructions documented the resident used a manual wheelchair with pressure relieving cushion, anti-rollback devices, and bilateral leg rests for mobility. Resident #22 was observed: - On 8/14/2024 at 11:00 AM, 12:49 PM, and 1:35 PM sitting in a scoot chair at a table in the unit dining room. - On 8/15/2024 at 9:55 AM, sitting in a scoot chair in their room. - On 8/16/2024 from 9:58 AM through 12:23 PM, sitting in a scoot chair at a table in the unit dining room. - On 8/19/2024 at 9:22 AM, sitting in a scoot chair at a table in the unit dining room. The 8/19/2024 at 2:36 PM Registered Nurse #17 progress note documented a therapy referral for proper wheelchair positioning. The 8/19/2024 Registered Nurse #17 restraint assessment for a scoot chair with matrix cushion documented the resident was unable to rise from the device, could not rise from any seating device, and therefore it was not considered a restraint. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/20/2024 at 10:07 AM, the resident was sitting in the unit dining room in a manual wheelchair with anti-tippers and bilateral leg rests. The resident was sliding down in the chair and was assisted by staff to a better seated position. During an interview on 8/19/2024 at 12:23 PM, Occupational Therapist #19 stated the resident was referred to therapy for a bed wedge evaluation on 7/31/2024. They did not evaluate the resident for the scoot chair. The evaluation documented the resident used a wheelchair prior to onset and not a scoot chair. The resident was using the scoot chair when they were evaluated. The resident was unable to rise by themselves from any type of chair. The process for use of a scoot chair was an order for an evaluation was obtained, nursing was consulted, a therapy referral/evaluation was obtained, the resident was assessed, and the most appropriate chair was provided per recommendation. During an interview on 8/19/2024 at 12:38 PM the Director of Therapy stated the resident was discharged from therapy on 7/10/2024 and was using a manual wheelchair. If the resident was not sitting well in a wheelchair, they would get an order for a therapy referral to assess for a different kind of chair. No referral was obtained from nursing for a scoot chair. Nursing was able to implement a scoot chair, but a therapy referral was still needed per policy. Nursing should have completed a restraint assessment for the scoot chair. The resident was unable to rise by themself from any type of chair. The care plan should have been updated by therapy or nursing. During an interview on 8/19/2024 at 1:02 PM, Certified Nurse Aide #20 stated the resident used a scoot chair since being transferred to the unit about two months ago. They did not know who gave the resident the scoot chair. The type of chair the resident used was supposed to be current in the resident's care plan, as that was how staff knew which chair to provide the resident daily. The current care plan documented the resident was to have a manual wheelchair with anti-rollbacks and leg rests. Staff should notify the Unit Manager if the resident did not have the planned equipment. During an interview on 8/20/2024 at 11:27 AM, Registered Nurse Manager #18 stated nursing and/or therapy were responsible for updating a resident's care plan when changes were made. Nursing should submit a referral to therapy and therapy evaluated and issued the most appropriate chair. In the case of a scoot chair, nursing should complete a restraint assessment. They did not know who initially issued the resident a scoot chair, but a therapy referral and restraint assessment should have been done. They were not aware the resident was not using the manual wheelchair. During an interview on 8/20/2024 at 12:05 PM, the Director of Nursing stated resident-specific care should be documented in the care plan and care instructions. The Unit Managers were responsible for updating the care plans. All scoot chairs should have a therapy evaluation and a restraint assessment completed by nursing to determine the appropriateness of the scoot chair. A progress note should also be completed by nursing and therapy. 10 NYCCR 415.11(c)(2)(iii)

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NAME OF PROVIDER OR SUPPLIER Iroquois Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 Southwood Heights Drive Jamesville, NY 13078	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37516 Based on observation, record review, and interview during the recertification survey conducted 8/14/2024 - 8/20/2024, the facility did not ensure that residents who required dialysis services received such services consistent with professional standards of practice for 1 of 1 resident (Resident #301) reviewed. Specifically, Resident #301 received hemodialysis (a process of purifying blood when the kidneys do not work properly) treatments at a community-based dialysis center and did not have a Comprehensive Care Plan that addressed dialysis. Findings include: The undated facility policy, Dialysis, documented the purpose of the policy was to provide proper care for residents receiving dialysis at an external facility. General guidelines included nursing staff observing the resident after returning from each dialysis treatment for their tolerance of the procedure, meals taken, dressing condition, and any other pertinent information as indicated, and to notify the registered nurse of any abnormal findings. Any bleeding from external catheters and fistulas/grafts indicated a medical emergency and required notification of the medical provider. Resident #301 had diagnoses including end-stage renal (kidney) disease and dependence on renal dialysis. The 8/6/2024 Minimum Data Set assessment documented the resident was cognitively intact, received a therapeutic diet, had intravenous access, and required hemodialysis treatments. The 8/1/2024 Registered Nurse #13 Clinical Admission Assessment documented the resident had a double lumen peripherally inserted central catheter (a flexible tube inserted into a vein in the upper arm used for intravenous access for administration of medications and not used for dialysis). The assessment did not document the resident received hemodialysis or the presence of external catheters, fistulas, or grafts used for dialysis access. The 8/1/2024 physician orders documented: - Dialysis Monday, Wednesday, and Friday; transport pick-up time 6:00 AM and return time 12:00 PM. - Dialysis communication book to go with resident to dialysis and returned from dialysis. Concerns to be reported to Unit/Clinical manager. - No blood pressures or blood draws from dialysis shunt extremity. - Weights done at dialysis. - Food to be offered to resident upon returning from dialysis. - Monitor atrioventricular fistula (a connection between an artery and a vein for dialysis) left arm every shift for redness, edema, and drainage and palpate site for thrills (vibrations caused by blood flowing through the fistula)/listen for bruit (whooshing sound) over access site. If no thrill, notify Nursing Supervisor/Unit Manager immediately. (continued on next page)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated on 8/1/2024 did not include the need for dialysis and interventions for care. During an observation on 8/15/2024 at 9:44 AM, Resident #301 was sitting in their room watching television. They stated they went to a community-based dialysis center on Monday, Wednesday, and Friday. They took a cab to dialysis, and it was 5 minutes away. During an interview on 8/16/24 at 10:16 AM, Registered Nurse Unit Manager #12 stated there was no dialysis care plan for Resident #301. They did updates to resident care plans, and there should have been a dialysis care plan with interventions. They thought the Assistant Director of Nursing or Director of Nursing did the admission care plan. Registered Nurse #13 had done the initial admission assessment for Resident #301, and they documented the resident had a peripherally inserted central catheter in their right upper chest (for antibiotic therapy) and a former chest tube site, but nothing about the resident having an atrioventricular fistula for dialysis. During an interview on 8/16/24 at 10:42 AM, the Assistant Director of Nursing stated Resident #301 did not have a dialysis care plan. All residents on admission had a baseline care plan. The Nurse Manager or whomever did the initial admission would put particulars in a care plan. They stated they needed to find some more information and would be back (they briefly left the interview). When they returned at 10:48 AM they stated a resident's dialysis care plan should be under the renal topic area, but Resident #301 did not have one. It meant they were not following the medical orders by not having a renal care plan. They also reviewed the certified nurse aide instructions and there was no information regarding dialysis. During an interview on 8/16/24 at 11:03 AM, Registered Nurse #13 stated they admitted Resident #301. When they did the initial admission assessment there should have been an area to address ports on the form and there were not any. They knew the resident had a port, but they did not know where to effectively document that. There should have been a renal care plan, and they should have done the updates for renal failure. A renal care plan should have interventions for monitoring the dialysis site. During an interview on 8/16/24 at 1:33 PM, the Director of Nursing stated registered nurses all worked together during an initial resident admission. The baseline care plan was done by whomever was assigned to do so, then the admissions registered nurse checked to make sure the care plan was accurate. Registered Nurse #13 should have checked the topic area that would have covered the resident's dialysis. It should be documented under renal function. It was important for the certified nurse aide care instructions to contain information about a residents' dialysis status so they would know when a resident should be ready to leave for dialysis. Resident #301 should have had a renal care plan so that interventions could have been followed. 10 NYCRR 415.12(k)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 37516 Based on observations and interviews during the recertification survey conducted 8/14/2024-8/20/2024, the facility did not ensure nurse staffing information was posted daily at the beginning of each shift and included the total number and actual hours worked by registered nurses, licensed practical nurses, and certified nurse aides for 4 of 5 days of survey. Specifically, daily nurse staffing was not posted daily at the beginning of the shift as required on 8/14/2024, 8/15/2024, 8/16/2024, and 8/19/2024 as required. Findings include: The facility did not have a policy on posting daily nurse staffing. The following observations were made in the main lobby: - on 8/14/2024 at 9:40 AM and 4:35 PM, the daily nurse staffing was posted in a clear plastic frame on a shelf and was dated 8/13/2024 with the day shift (7:00 AM - 3:00 PM) nurse staffing only. - on 8/15/2024 at 4:40 PM the posted daily nurse staffing was dated 8/13/2024. - on 8/16/2024 at 9:01 AM the daily nurse staffing posted was dated 8/13/2024. At 10:07 AM, the posted daily nurse staffing was dated 8/16/2024 and documented nursing staff for the day shift. - on 8/19/2024 at 8:45 AM and 10:47 AM there was no posted daily nurse staffing. At 12:16 PM the posted daily nurse staffing was for the day shift on 8/19/2024. During an interview on 8/20/2024 at 10:05 AM, Administrative Assistant/Day Staffing Coordinator #15 stated they did the day shift nurse staffing schedule every day. They were not aware the daily nurse staffing posted in the lobby on 8/14/2024, 8/15/2024 and 8/16/2024 was not current and had remained dated 8/13/2024. The evening shift staffing coordinator, who was new, might have taken the schedule out of the clear plastic frame and not put it back, or the staffing schedule may have been set aside when they took it to the front lobby desk. The night (11:00 PM - 7:00 AM) Registered Nurse Supervisor did the night shift staffing schedule but they had not been posting it in the lobby. During an interview on 8/20/2024 at 10:15 AM the Administrator stated they were not aware the posted daily nurse staffing schedule was not current on 8/14/2024, 8/15/2024 and 8/16/2024 or that the schedule was absent throughout the morning on 8/19/2024. The day and evening shift staffing schedules should have been posted before the shifts started. 10 NYCRR 415.13